## Organization Information

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| **Organization Name:** | Brigham and Women's Hospital |
| **Address:** | 75 Francis Street |
| **City, State, Zip:** | Boston, Massachusetts 02115 |
| **Website:** | www.brighamandwomens.org |
| **Contact Name:** | Wanda McClain |
| **Contact Title:** | Vice President of Community Health and Health Equity |
| **Contact Department (Optional):** | Center for Community Health and Health Equity |
| **Phone:** | (617) 264-8750 |
| **Fax (Optional):** | (617) 264-8756 |
| **E-Mail:** | wmcclain@partners.org |
| **Contact Address:** (Optional, if different from above) | 75 Francis Street |
| **City, State, Zip:** (Optional, if different from above) | Boston, Massachusetts 02115 |

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| **Organization Type:** | Hospital |
| **For-Profit Status:** | Not-For-Profit |
| **Health System:** | Partners HealthCare |
| **Community Health Network Area (CHNA):** | Alliance for Community Health (Boston/Chelsea/Revere/Winthrop)(CHNA 19), |
| **Regions Served:** | Boston, |

## Mission and Key Planning/Assessment Documents

**Community Benefits Mission Statement:**

Brigham and Women's Hospital (BWH) is committed to serving the health care needs of persons from diverse communities. The hospital, however, makes a unique commitment to the neighboring residents of Jamaica Plain and Mission Hill, who have some of the most pressing health problems in the state. The hospital, along with its two licensed community health centers (CHCs), is committed to developing integrated care networks to provide and assure appropriate access to high quality, cost-effective primary care to members of these communities regardless of their insurance status. The hospital also commits to meeting the needs of low-income pregnant women and their families from the communities of Mattapan, Roxbury and Dorchester.

In order to address the health needs of its target communities, the hospital must look beyond its walls and seek guidance from the community to implement programs that recognize and address the relationships between health and social problems, including economic and educational issues. The hospital is committed to collaborating with community groups and organizations to develop comprehensive programs that respond to the needs of the communities, as identified by the communities themselves, and as suggested by public health and other data. BWH seeks to improve the health status of residents of the communities by offering health services, continuing and expanding innovative community and school-based programs, and by serving as a resource to the community as a liaison to health careers education and as a possible employer of community residents.

**Target Populations:**

| Name of Target Population | Basis for Selection |
|---|---|
| Boston residents experiencing health inequities | Evidence of racial and ethnic health disparities in birth outcomes, cardiovascular disease, cancer and chronic conditions. |
| Medically underserved and/or low-income women in BWH's priority neighborhoods (Dorchester, Jamaica Plain, Mattapan, Mission Hill and Roxbury) | Evidence of persistent health disparities in rates of infant mortality and chronic disease for communities of color and need by low income women to meet the costs of breast cancer treatment that are not covered by health insurance. |

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| Medically underserved and/or low-income residents of BWH's priority neighborhoods | Evidence of pressing and persistent health and social needs. |
| Victims of violence | A growing body of science is consistently linking violence (the experience with and/or fear of) with risk for and incidence of a range of serious physical health problems. The effects of violence on health are a consequence of the physical, biological, environmental, social, behavioral, and emotional changes that violence imposes on individuals and the community. |
| Young people in BWH priority communities | There is a high rate of family poverty as well as a large youth population in BWH's priority communities. By providing educational and employment opportunities in the health, science and medical field to young people, BWH is able to impact the long term health and economic status of those communities. |
| Native Americans | Significantly poorer health outcomes and health access for Native Americans. |

**Publication of Target Populations:**
Marketing Collateral, Annual Report, Website

**Community Health Needs Assessment:**

**Date Last Assessment Completed:**

2019

**Data Sources:**

Community Focus Groups, Interviews, Surveys,

**CHNA Document:** CHNA-CHIP-2019_3.6.20.PDF

**Implementation Strategy:**

**Implementation Strategy Document:** BWH CHIP 2019 - FINAL.PDF

**Key Accomplishments of Reporting Year:**

- The Passageway domestic violence program provided 1,087 counseling sessions and contacts to or on behalf of 837 patients, employees, or community members experiencing domestic violence.
- The Violence Recovery Program team members attended 212 different meetings and events to raise awareness and work collaboratively on issues of violence exposure.
- One hundred percent of alumni of the Student Success Jobs Program (SSJP) entered college after SSJP or have graduated college, and 63% of those students majored in a health or science field. Sixty percent reported that they were first in their family to enroll in college.
- Over 500 young people received educational support and mentoring from nearly 300 Brigham and Women's Hospital employees.
- Stronger Generation's Baby CafÃ©, which started in FY17, provided free, community-based breastfeeding support through trained lactation professionals to 88 women at the Baby CafÃ© site at Southern Jamaica Plain Health Center.
- More than 480 women received pregnancy and parenting services from health center-based case managers through the Stronger Generations Case Management Program.
- Our two BWH licensed community health centers in Jamaica Plain (Brookside Community Health Center and Southern Jamaica Plain Health Center) served over 21,000 patients with about 82,700 visits.
- Ten BWH Health Equity grantee organizations served nearly 2,000 Boston-area resident providing services aimed at improving psychological wellness, expanding economic opportunities and addressing racial equity.

**Plans for Next Reporting Year:**

- Continue expansion of effective programs to increase educational and employment opportunities for young people in the community, including the Science in the Classroom program at our partnering schools.
- Continue to develop interventions that promote positive maternal and infant health outcomes through a focus on family and community engagement, holistic health and wellness, and innovative approached to addressing the social determinants of health

within our health system, as part of our Stronger Generations initiative.
- Continue intentional collaboration among all violence intervention and prevention programs; explore expansion to include sexual assault advocacy; implement new trafficking intervention program (TIP) collaboratively with Beth Israel Lahey Health to address human trafficking.

**Self-Assessment Form:** Hospital Self-Assessment Form - Year 1

## Community Benefits Programs

| Brigham and Women's Hospital - Maurice J. Tobin School Partnership | |
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| **Program Type** | Total Population or Community-Wide Interventions |
| **Program is part of a grant or funding provided to an outside organization** | Yes |
| **Program Description** | For 27 years, BWH and the Maurice J. Tobin School in Mission Hill have partnered to support the school's academic mission, which seeks "to implement a rigorous academic program and opportunities for artistic expression, high and clear expectations for the entire school community in an atmosphere that is safe, nurturing, respectful and inspiring." BWH does this by supporting and participating in efforts that increase parent, family, community, and hospital involvement in students' learning. With the established link between educational attainment and health status, this partnership was created to support the hospital's mission of improving the health status of the Mission Hill community.<br><br>Elements of the program are designed to engage hospital employees in students' education. Further, in FY19, efforts were made to support students and teachers directly in the classroom in order to improve educational outcomes and achievement.<br><br>In FY19, 437 children and their families participated. Since inception in 1991, approximately 11,672 students and their families have had access to services provided by the Brigham and Women's Hospital- Maurice J. Tobin Partnership. |
| **Program Hashtags** | Community Education, Mentorship/Career Training/Internship, |
| **Program Contact Information** | Pamela Audeh, Program Director, Center for Community Health and Health Equity, Brigham and Women's Hospital, 41 Avenue Louis Pasteur, Boston, MA 02115 |

**Program Goals:**

| Goal Description | Goal Status | Goal Type | Time Frame |
|---|---|---|---|
| Support the school's academic mission by increasing parent, family, community and hospital involvement in students' learning. | In FY19, 437 children and their families were served; since inception (1991), approximately 11,672 students and their families have been served. | Process Goal | Year 3 of 3 |
| Support the school's academic mission by increasing BWH employee involvement. | In FY19, 31 BWH employees volunteered to be matched with a Tobin student in need of additional assistance, as identified by school faculty, to read to once a week for an hour for the school year through the non-profit, Read to a Child. | Outcome Goal | Year 3 of 3 |
| Create a continuum of services for students and families to support their emotional, social and academic needs. | In FY19, all grade K-8 teachers (26) received instructional support in literacy initiatives, and all 437 students participated in numerous trips and activities to support their learning. | Outcome Goal | Year 3 of 3 |
| Create a continuum of services for students and families to support their emotional, social and academic needs. | In FY19, students received additional supports in reading, technology and science including hands on science instruction, and online academic supports. | Outcome Goal | Year 3 of 3 |

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| **EOHHS Focus Issues** | N/A, |
| **DoN Health Priorities** | Education, Social Environment, |
| **Health Issues** | Social Determinants of Health-Education/Learning, Social Determinants of Health-Language/Literacy, |
| **Target Populations** | • **Regions Served:** Boston-Mission Hill, |

- **Environments Served:** Urban,
- **Gender:** All,
- **Age Group:** All,
- **Race/Ethnicity:** All,
- **Language:** All,
- **Additional Target Population Status:** Not Specified

**Partners:**

| Partner Name and Description | Partner Website |
|---|---|
| Achievement Network | http://www.achievementnetwork.org/ |
| Greater Boston Food Bank | http://www.gbfb.org/ |
| Maurice J. Tobin K8 School | http://www.bostonpublicschools.org/school/tobin-k-8-school |
| Read to a Child | http://www. readtoachild.org |
| Science from Scientists | http://www.sciencefromscientists.org/ |
| America Scores | http://www.americascores.org/about-us/program |
| Tutors for All | https://www.tutorsforall.org/ |

## Brigham and Women's Hospital - Mission Hill Community Activities

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| **Program Type** | Total Population or Community-Wide Interventions |
| **Program is part of a grant or funding provided to an outside organization** | Yes |
| **Program Description** | Brigham and Women's Hospital (BWH) has a long-standing commitment to improving the health status of Boston residents, with a focus on Boston neighborhoods surrounding the hospital with disproportionately poor health and social outcomes, and documented need for comprehensive health and social services.<br><br>BWH makes a unique commitment to the neighboring residents of Mission Hill; this commitment involves financial and programmatic support for numerous Mission Hill organizations and activities. The primary objectives of the BWH Mission Hill Community Activities are supporting neighborhood schools, youth serving organizations, anti-poverty programs, housing and public health initiatives, and employment and business development throughout Mission Hill. |
| **Program Hashtags** | Community Education, Health Screening, Prevention, |
| **Program Contact Information** | Shirma Pierre, Operations and Projects Director, Center for Community Health and Health Equity, Brigham and Women's Hospital, 41 Avenue Louis Pasteur |

**Program Goals:**

| Goal Description | Goal Status | Goal Type | Time Frame |
|---|---|---|---|
| Provide support to neighborhood schools, youth serving organizations, anti-poverty programs, housing and public health initiatives, and employment and business development throughout Mission Hill | In FY19, provided over $815,000 in cash support to Mission Hill organizations and programs that provide resources to Mission Hill residents. In addition to cash support, BWH provides in-kind support and other resources to Mission Hill community organizations. | Process Goal | Year 3 of 3 |
| Increase economic development opportunities and education and training for youth in Mission Hill | In addition to year-round and summer educational and employment opportunities that benefit more than 360 Mission Hill youth, BWH provides support to Mission Hill youth serving organizations to create 6 summer jobs for neighborhood youth. | Outcome Goal | Year 3 of 3 |
| Partner with community-based organizations to ensure access to food within the underserved population in Mission Hill | In FY19, BWH worked in close partnership with the Parker Hill/Fenway ABCD Emergency Food Pantry. As a founding member of the Mission Hill/Fenway Food Project, BWH makes a financial contribution to allow the food pantry to purchase food items that are not readily available from the Boston Food Bank. BWH also held its annual food drive which netted several hundred pounds of food items that went directly to support the emergency food pantry at ABCD. | Process Goal | Year 3 of 3 |

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| Facilitate access to BWH healthcare facilities/services for the Mission Hill community | In FY19, BWH collaborated with a major Mission Hill organization to provide a free flu clinic to 35 Mission Hill seniors. In addition, BWH participated in several neighborhood health fairs and several neighborhood health education presentations. | Process Goal | Year 3 of 3 |
| Contribute to the commercial vitality of the Mission Hill neighborhood. | In FY19, BWH continued to serve as the corporate buddy for Mission Hill Main Streets and holds a seat on its board of directors. BWH supplements its financial support by contributing to a range of community projects, and promotional support for the organization's activities, as well as meeting other responsibilities of being a corporate buddy.<br>In addition, BWH launched its Local Flavors Initiative aimed at increasing the number of BWH employees who buy at Mission Hill restaurants. | Process Goal | Year 3 of 3 |
| Increase access to employment at the Brigham for residents of Mission Hill | Mission Hill community residents have access to BWH's Human Resources satellite office located at 741 Huntington Avenue where they are able to inquire about job availability, apply online and/or meet with a workforce development specialist. One thousand, one hundred and twenty-one (1,121) Boston residents visited our satellite office in FY19. Of those who visited, 159 were Mission Hill residents. | Process Goal | Year 3 of 3 |

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| **EOHHS Focus Issues** | N/A, |
| **DoN Health Priorities** | Education, Employment, Social Environment, |
| **Health Issues** | Social Determinants of Health-Access to Health Care, Social Determinants of Health-Access to Healthy Food, Social Determinants of Health-Affordable Housing, Social Determinants of Health-Domestic Violence, Social Determinants of Health-Education/Learning, Social Determinants of Health-Language/Literacy, Social Determinants of Health-Violence and Trauma, |
| **Target Populations** | • **Regions Served:** Boston-Mission Hill,<br>• **Environments Served:** Urban,<br>• **Gender:** All,<br>• **Age Group:** All,<br>• **Race/Ethnicity:** All,<br>• **Language:** All,<br>• **Additional Target Population Status:** Not Specified |

**Partners:**

| Partner Name and Description | Partner Website |
|---|---|
| Mission Church Grammar School | http://www.missiongrammar.org/ |
| Mission Hill Health Movement | http://www.mhhm.org/ |
| Mission Hill Little League | http://www.eteamz.com/missionhill |
| Mission Hill Main Streets | http://www.missionhillmainstreets.org/ |
| Mission Hill Neighborhood Housing Services | http://missionhillnhs.org/ |
| Roxbury Tenants of Harvard | http://www.roxburytenants.org/ |
| Sociedad Latina | http://www.sociedadlatina.org/ |
| Tobin Community Center | https://www.boston.gov/community-centers/bcyf-tobin |
| Maurice J. Tobin K-8 School | http://www.bostonpublicschools.org/school/tobin-k-8-school |
| Mission Hill Senior Legacy Group | Not Specified |

## Brigham and Women's/Mass General Health Care Center (BW/MG HCC)

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| **Program Type** | Community-Clinical Linkages |
| **Program is part of a grant or funding provided to an outside organization** | No |
| **Program Description** | The goal of the Brigham and Women's/Mass General Health Care Center is to provide the same |

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| | standard of high-quality care and services found at our main campus in a location more convenient for our patients. Moreover, the Center strives to provide maximum patient convenience and care by locating many specialty services under one roof.<br><br>In addition to providing direct clinical services, we aim to support community-based initiatives that educate community residents and partner with local organizations to address significant health-related needs. In FY19, our community outreach and education efforts have worked with over 1,500 people and over 7,700 since the health center's inception in 2009. |
| **Program Hashtags** | Community Education, Support Group, |
| **Program Contact Information** | Cindy Peterson, Executive Director, Brigham and Women's/Mass General Health Care Center (BW/MG HCC) 20 Patriot Place Foxborough, MA 02035 |

**Program Goals:**

| Goal Description | Goal Status | Goal Type | Time Frame |
|---|---|---|---|
| Supporting community educational initiatives by local organizations in the greater Foxborough elder population. | In FY19, we helped increase HESSCO's reach within the community through sponsorship of its annual 5K Fundraising Run. | Process Goal | Year 3 of 3 |
| Provide free spring and fall health classes designed for consumers in the greater Foxborough community. | In FY19, we held 3 free Community Spring Lectures with a total of 60 people in attendance. In the Spring, we also held 2 free community vein screenings with a total of 27 in attendance. In the fall, we manned a booth handing out promotional items and wellness quizzes to youth in the Hockomock YMCA's Healthy Kids Day, with over 1,000 in attendance . | Process Goal | Year 3 of 3 |
| Present general health education information to the greater Foxborough community via speakers' bureau and other options. | Working in tandem with the Fish Center for Women's Health and the Osher Center for Integrative Medicine at Brigham Health-Chestnut Hill, our Center sponsored a "Women's Health and Resiliency" lecture along with the Tri-Town and Neponset River Regional Chambers of Commerce. | Process Goal | Year 3 of 3 |
| Participate in domestic violence (d/v) and violence prevention & wellness/health education in greater Foxborough community. | Proponent and supporter of local d/v educational/advocacy organizations (HUGS-Foxboro, and local D/V support group run by Foxborough Human Services); significant contributor to two local Chambers of Commerce and community, eldercare, and health-related awareness-building around various options. | Process Goal | Year 3 of 3 |
| Support local violence prevention and domestic violence (d/v) awareness work as well as substance use disorder awareness-building in Foxborough community. | In FY19, support included promotion and fundraising assistance for HUGS & D/V support group members, and general awareness-building around substance use disorder through fundraising support for the SAFE Coalition (representing 12 towns including Foxborough). | Process Goal | Year 3 of 3 |
| Provide support to local community organizations addressing key health issues. Community support provided to local organizations addressing key health issues. | In FY19, allocated employee resources to participate in the Foxborough Public Schools' school-to-career partnerships, local YMCA, Foxborough Discretionary Fund, and holiday food drive (via Jaycees). Provided several food donations to the Foxborough Food Pantry and SAFE Coalition. Provided wellness items to the Town of Foxborough Employee Health Day. Offered employee participation and sponsorship in HESSCO Elder Services and donated various retailer gift cards for members of the HUGS-Foxborough domestic violence program. | Process Goal | Year 3 of 3 |
| Provide support to local community organizations addressing key health issues. Community support provided to local organizations addressing key health issues. | In FY19, supported local area communities through both participation and sponsorship of programs in the Neponset River Region Chamber of Commerce's Eldercare & Health/Wellness Alliance, and Tri-Town Chamber of Commerce Community Relations efforts, which focused on raising the profile of small local non-profits. | Process Goal | Year 3 of 3 |

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| **EOHHS Focus Issues** | N/A, |
| **DoN Health Priorities** | Education, Social Environment, Violence, |
| **Health Issues** | Injury-Home Injuries, Other-Senior Health Challenges/Care Coordination, Social Determinants of Health-Domestic Violence, Social Determinants of Health-Nutrition, Substance Addiction-Substance Use, |

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| **Target Populations** | • **Regions Served:** Canton, Dedham, Foxborough, Franklin, Mansfield, Medfield, Medway, North Attleboro, Norwood, Plainville, Sharon, Stoughton, Walpole,<br>• **Environments Served:** All,<br>• **Gender:** All,<br>• **Age Group:** All,<br>• **Race/Ethnicity:** All,<br>• **Language:** All,<br>• **Additional Target Population Status:** Domestic Violence History, |

**Partners:**

| Partner Name and Description | Partner Website |
|---|---|
| Foxboro Jaycees | http://www.foxborojaycees.org/ |
| Foxborough Human Services & COA | http://www.foxboroughma.gov/Pages/FoxboroughMA_COA/index |
| HESSCO Elder Services | http://www.hessco.org/ |
| SchooltoCareer Partnership | www.schooltocareer.info |
| TriTown Chamber of Commerce | http://www.tri-townchamber.org/ |
| Neponset River Regional Chamber | http://www.nvcc.com/ |
| Foxboro Food Pantry | http://www.foxborofoodpantry.com |
| Norton Cupboard of Kindness | http://www.cupboardofkindness.org/ |
| Hockomock YMCA | https://www.hockymca.org/ |
| Town of Foxborough | http://foxboroughma.gov/ |
| Safe Coalition | https://www.safecoalitionma.org/ |

## Brookside Community Health Center

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| **Program Type** | Direct Clinical Services |
| **Program is part of a grant or funding provided to an outside organization** | No |
| **Program Description** | The mission of Brookside Community Health Center is to provide high quality, family-oriented, comprehensive health care, with a focus on serving the low-income population of the community. Moreover, Brookside strives to: 1. Continue to be recognized as a leader in the delivery of high quality, multi-disciplinary, integrated family-oriented health care and as a model program for community-based primary care within the Brigham and Women's, Brigham and Women's Faulkner Hospitals, and Partners HealthCare Systems. 2. Continue to offer successful programs training practitioners in the provision of community-based, culturally appropriate health care, and maintain a focus on the delivery of primary care. 3. Maintain a leadership role in developing programs designed to improve the health status of Jamaica Plain and the surrounding communities. |
| **Program Hashtags** | Community Education, Health Screening, Prevention, |
| **Program Contact Information** | Margaret (Mimi) Jolliffe, Executive Director, Brookside Community Health Center, 3297 Washington Street, Jamaica Plain, MA 02130 |

**Program Goals:**

| Goal Description | Goal Status | Goal Type | Time Frame |
|---|---|---|---|
| Provide high quality, family-oriented, comprehensive health care, with a focus on serving the low-income population of the community, regardless of ability to pay. | In FY19, there were 34,000 routine and well visits and nearly 7,800 behavioral health visits. The total panel size across all departments is 11,000 patients. | Process Goal | Year 3 of 3 |
| Expand integrating behavioral health in medical department visits. | Expanded integrated hours after a successful pilot to include one social worker embedded in the medical department every day from 1-5 p.m. and a social worker 'on-call' in the morning hours if patients need behavioral health services. Looking to expand to morning hours more permanently in FY20. | Outcome Goal | Year 3 of 3 |

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| Continue nutrition presence in pediatrics department. | Having a nutritionist embedded in pediatrics allowed for more real-time patient referrals and fewer phone calls and outreach attempts; patients and their families can be engaged immediately. | Process Goal | Year 3 of 3 |
| Continue participation in the JP Neighborhood Trauma Team. | Collaborate with Southern Jamaica Plain and BWH Violence Intervention and Prevention Program as well as with Tree of Life and other community agencies to address the needs of individuals impacted by homicides and gun violence in our community more immediately. | Process Goal | Year 3 of 3 |
| Maintain/exceed established clinical excellence in all departments. | Expanded group visits and classes across Brookside, including a meditation/yoga class for individuals with chronic pain and depression, a diabetes series that incorporated nutrition, nursing and behavioral health, and an adolescent young women's group. Started initial pilot for group visits for patients with chronic pain. | Process Goal | Year 3 of 3 |

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| **EOHHS Focus Issues** | Chronic Disease with focus on Cancer, Heart Disease, and Diabetes, Housing Stability/Homelessness, Mental Illness and Mental Health, Substance Use Disorders, |
| **DoN Health Priorities** | Housing, Social Environment, Violence, |
| **Health Issues** | Cancer-Breast, Cancer-Cervical, Cancer-Colorectal, Cancer-Lung, Cancer-Multiple Myeloma, Cancer-Other, Cancer-Ovarian, Cancer-Prostate, Cancer-Skin, Chronic Disease-Alzheimer's Disease, Chronic Disease-Arthritis, Chronic Disease-Asthma/Allergies, Chronic Disease-Cardiac Disease, Chronic Disease-Chronic Pain, Chronic Disease-Colitis/Crohn's Disease, Chronic Disease-Diabetes, Chronic Disease-Hypertension, Chronic Disease-Osteoporosis, Chronic Disease-Overweight and Obesity, Chronic Disease-Pulmonary Disease, Chronic Disease-Sickle Cell Disease, Chronic Disease-Stroke, Health Behaviors/Mental Health-Bereavement, Health Behaviors/Mental Health-Depression, Health Behaviors/Mental Health-Immunization, Health Behaviors/Mental Health-Mental Health, Health Behaviors/Mental Health-Physical Activity, Health Behaviors/Mental Health-Responsible Sexual Behavior, Health Behaviors/Mental Health-Stress Management, Infectious Disease-Hepatitis, Infectious Disease-HIV/AIDS, Infectious Disease-Lyme Disease, Infectious Disease-Sexually Transmitted Diseases, Infectious Disease-Tuberculosis, Injury-Auto/Passenger Injuries, Injury-First Aid/ACLS/CPR, Injury-Home Injuries, Injury-Other, Injury-Sports Injuries, Maternal/Child Health-Child Care, Maternal/Child Health-Family Planning, Maternal/Child Health-Menopause, Maternal/Child Health-Parenting Skills, Maternal/Child Health-Reproductive and Maternal Health, Other-Cultural Competency, Other-Dental Health, Other-Emergency Preparedness, Other-Hearing, Other-Hospice, Other-Senior Health Challenges/Care Coordination, Other-Vision, Social Determinants of Health-Access to Health Care, Social Determinants of Health-Access to Healthy Food, Social Determinants of Health-Access to Transportation, Social Determinants of Health-Affordable Housing, Social Determinants of Health-Domestic Violence, Social Determinants of Health-Education/Learning, Social Determinants of Health-Environmental Quality, Social Determinants of Health-Homelessness, Social Determinants of Health-Income and Poverty, Social Determinants of Health-Language/Literacy, Social Determinants of Health-Nutrition, Social Determinants of Health-Public Safety, Social Determinants of Health-Racism and Discrimination, Social Determinants of Health-Uninsured/Underinsured, Social Determinants of Health-Violence and Trauma, Substance Addiction-Alcohol Use, Substance Addiction-Driving Under the Influence, Substance Addiction-Opioid Use, Substance Addiction-Smoking/Tobacco Use, Substance Addiction-Substance Use, |
| **Target Populations** | • **Regions Served:** Boston,<br>• **Environments Served:** Urban,<br>• **Gender:** All,<br>• **Age Group:** All,<br>• **Race/Ethnicity:** All,<br>• **Language:** All,<br>• **Additional Target Population Status:** Not Specified |

**Partners:**

| Partner Name and Description | Partner Website |
|---|---|
| Boston Alliance for Community Health | http://www.bostonhealthalliance.org/ |
| Boston Centers for Youth & Families | http://www.cityofboston.gov/bcyf/ |
| Camp Harborview | http://www.chvf.org/ |

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| Center for Community Health Education Research and Service, Inc. (CCHERS) | http://www.ccher.org/index.htm |
| ESAC | http://www.esacboston.org/ |
| Fitz Urban Youth Sports | http://sportscorps.net/aboutfysi/ |
| Jamaica Plain Neighborhood Development Corporation | http://www.jpndc.org/ |
| JP Health Planning | www.intercreativadesign.com/jphealthplanning/ |
| JP VIP & Trauma Response Team | Not Specified |
| JP Youth Disparities Initiative | Not Specified |
| Martha Eliot Health Center | http://www.childrenshospital.org/locations/Site1395/mainpageS1395P57sublevel8.html |
| Roxbury YMCA | http://www.ymcaboston.org/roxbury/ |
| Urban Edge | http://www.urbanedge.org/ |

## BWH Health and Science Initiative

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| **Program Type** | Total Population or Community-Wide Interventions |
| **Program is part of a grant or funding provided to an outside organization** | No |
| **Program Description** | The Health and Science Initiative provides an informal learning environment that enables elementary and middle school students to learn about health, science and medicine via a hands-on approach. Elementary school students work together on science experiments in small groups led by hospital employees and listen to presentations by BWH staff guest speakers. Middle School students do hands on science with BWH sponsored Science from Scientists and participate in a yearlong public health class taught by BWH staff. The relaxed, yet structured atmosphere promotes teamwork and produces cooperative learning experiences that increase science knowledge. All Health and Science Initiative curricula are aligned to the Massachusetts state science curriculum frameworks and standards. The Health and Science Initiative also exposes students to new health careers and introduces them to the types of education and training that are necessary to pursue specific health career paths. Since program's 2006 inception, 1,288 students have been served in the Health and Science Initiative (95 students in FY19). |
| **Program Hashtags** | Community Education, Mentorship/Career Training/Internship, |
| **Program Contact Information** | Pamela Audeh, Center for Community Health and Health Equity, Brigham and Women's Hospital, 41 Avenue Louis Pasteur, Boston, MA 02115 |

**Program Goals:**

| Goal Description | Goal Status | Goal Type | Time Frame |
|---|---|---|---|
| Promote teamwork and enables cooperative learning experiences that increase science knowledge. | In FY19, 95 students from four classrooms were served. Since Inception (2006), 1,288 students have been served in the Health and Science Initiative. | Process Goal | Year 3 of 3 |
| To provide science exploration opportunities for fourth and fifth grade students in Mission Hill participating schools. | In FY19, elementary school students participated in three hands on science experiments and projects. Grade 3-5 students participated in hands on neuroscience lessons taught by physicians. These projects and classes are imbedded in the schools' science curriculum and comprise a large amount of the grade level science teaching. | Outcome Goal | Year 3 of 3 |
| To increase opportunities and excitement around doing science by working on science experiments selected by the participating schools each academic year. | In FY19, students in grades 4 and 5 had hands on science experience aligned to district curricula twice a month run by scientists; in addition, students in grade 3-5 also had hands on neuroscience lessons taught by physicians. | Outcome Goal | Year 3 of 3 |
| To provide health career exploration opportunities to fourth grade students. | In FY19, seven BWH employees volunteered in the Health and Science Initiative. Students learned about various careers in the hospital, as well as education needed to enter the healthcare field. | Outcome Goal | Year 3 of 3 |

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| **EOHHS Focus Issues** | N/A, |
| **DoN Health Priorities** | Education, |
| **Health Issues** | Social Determinants of Health-Education/Learning, Social Determinants of Health-Language/Literacy, |
| **Target Populations** | • **Regions Served:** Boston, Boston-Mission Hill,<br>• **Environments Served:** Urban,<br>• **Gender:** All,<br>• **Age Group:** Children,<br>• **Race/Ethnicity:** All,<br>• **Language:** All,<br>• **Additional Target Population Status:** Not Specified |

**Partners:**

| Partner Name and Description | Partner Website |
|---|---|
| Maurice J. Tobin School | http://www.bostonpublicschools.org/node/524 |
| Science from Scientists | http://www.sciencefromscientists.org/ |

## BWH Health Equity Grants

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|---|---|
| **Program Type** | Total Population or Community-Wide Interventions |
| **Program is part of a grant or funding provided to an outside organization** | Yes |
| **Program Description** | While notable advances have taken place in medical care, significant health inequities persist for communities of color. Much of the inequity in health outcomes is attributable to the social and economic conditions in which people live. Often referred to as the 'Social Determinants of Health,' factors including employment, education, financial stability, transportation access, affordable housing, systemic racism and exposure to violence all have a significant impact on the health of individuals and communities. Through the BWH Health Equity Grant initiative, the hospital provides funding to organizations working closely and effectively with community residents in one or more of BWH's five priority communities: Dorchester, Jamaica Plain, Mattapan, Mission Hill and Roxbury. Grants are awarded in three main areas that were identified by a robust community planning process. These are: 1) community psychological wellness and well-being, 2) employment and job skill development opportunities, and 3) addressing health inequity issues with a racial equity lens. |
| **Program Hashtags** | Community Education, Mentorship/Career Training/Internship, Prevention, |
| **Program Contact Information** | Michelle Keenan, Director, Community Programs; Center for Community Health and Health Equity, Brigham and Womenâ€™s Hospital; 617-264-8737 |

**Program Goals:**

| Goal Description | Goal Status | Goal Type | Time Frame |
|---|---|---|---|
| Address social factors that contribute to poor health outcomes by providing grant funding to local community organizations to allow them to extend their reach and increase their impact in BWH's priority neighborhoods. | In FY19, BWH provided health equity grant funding to 12 local organizations. Evaluation results showed that these organizations served 1,993 community residents, 70% of which had a known residency status in one of BWH's five priority neighborhoods. | Process Goal | Year 3 of 3 |
| Promote community psychological wellness and well-being. | Four grant funded community partners are engaged in community effort to promote community psychological wellness and well-being. These include a program designed to help young mothers who are incarcerated prepare for release with personal leadership training, financial literacy and parenting supports with mentoring that continues post-release when they are back in the communities with their families and children. Another grant funded program provides social and emotional support for program participants, families and staff for young people in out-of-school time programs. | Outcome Goal | Year 3 of 3 |

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|---|---|---|---|
| Strengthen employment and job skills development opportunities for community residents. | Five grant funded community partners are engaged in community efforts to strengthen employment and job skills development opportunities for community residents. This grant area includes a program to prepare highly disengaged and proven at-risk students with the skills and support networks needed to succeed; a job readiness program that offers trauma survivors next step skills training, work or secondary education options; and a program that supports low-income Latino young people primarily in the Mission Hill/Roxbury communities with skill building and exploration, internship placements and academic case management. | Outcome Goal | Year 3 of 3 |
| Address health inequity issues with a racial equity lens. | Three grant funded community partners are engaged in community efforts to address health inequity issues with a racial equity lens. Funded programs include multilingual interactive healthy cooking demonstration and nutrition education for parents and children as well as support for efforts to engaging community members in the Nubian Square neighborhood on the issue of the health and social impacts of residential displacement and work to strengthen resident involvement in local planning processes and inform policy development for community stabilization. | Outcome Goal | Year 3 of 3 |

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|---|---|
| **EOHHS Focus Issues** | N/A, |
| **DoN Health Priorities** | Education, Employment, Violence, |
| **Health Issues** | Social Determinants of Health-Access to Health Care, Social Determinants of Health-Access to Healthy Food, Social Determinants of Health-Access to Transportation, Social Determinants of Health-Affordable Housing, Social Determinants of Health-Domestic Violence, Social Determinants of Health-Education/Learning, Social Determinants of Health-Environmental Quality, Social Determinants of Health-Homelessness, Social Determinants of Health-Income and Poverty, Social Determinants of Health-Language/Literacy, Social Determinants of Health-Nutrition, Social Determinants of Health-Public Safety, Social Determinants of Health-Racism and Discrimination, Social Determinants of Health-Uninsured/Underinsured, Social Determinants of Health-Violence and Trauma, |
| **Target Populations** | • **Regions Served:** Boston,<br>• **Environments Served:** Urban,<br>• **Gender:** All,<br>• **Age Group:** All,<br>• **Race/Ethnicity:** All,<br>• **Language:** All,<br>• **Additional Target Population Status:** Not Specified |

**Partners:**

| Partner Name and Description | Partner Website |
|---|---|
| All Dorchester Sports League | https://www.alldorchestersports.org/ |
| Alternatives for Community and Environment | https://www.ace-ej.org/ |
| Baraka Community Wellness | https://www.barakawellness.org/ |
| College Bound Dorchester | http://collegebounddorchester.org/ |
| Mattapan Food and Fitness Coalition | http://www.mattapanfoodandfitness.org/ |
| MissionSAFE | http://www.missionsafe.org/ |
| Mothers for Justice and Equality | http://mothersforjusticeandequality.org/ |
| Sociedad Latina | https://www.sociedadlatina.org/ |
| St. Stephen's Youth Programs | http://www.ssypboston.org/ |
| The H.E.A.R.T. Consortium | https://www.hcacouncil.org/general/custom.asp?page=HEARTTrainingGran |
| Unitarian Universalist Urban Ministry | http://www.uuum.org/ |
| Urban League of Eastern Massachusetts | https://ulem.org/ |

## Connecting Hope, Assistance, and Treatment Program (CHAT)

| | |
|---|---|
| **Program Type** | Access/Coverage Supports |
| **Program is part of a grant or funding provided to an outside organization** | No |
| **Program Description** | The Connecting Hope, Assistance, and Treatment (CHAT) program provides financial assistance to low income, uninsured and underinsured women with breast cancer to help pay for necessary services related to their breast cancer diagnosis. In the absence of the CHAT program, many women are forced to forego the items related to their breast cancer treatment in order to pay for rent, utilities, food, and other basic necessities. In the face of many competing survival priorities, the CHAT program is able to assist in providing the resources necessary to ensure the emotional and physical wellbeing of breast cancer patients. In FY19, there were 23 women served by the CHAT program. The majority of resources provided to women were breast prosthesis/bra assistance, wigs and co-pay reimbursements for treatment appointments. Since inception in 2002, the CHAT program has provided services to over 1,200 women. |
| **Program Hashtags** | Community Education, Support Group, |
| **Program Contact Information** | Ariel Childs, Program Director, Stronger Generations Initiative, Center for Community Health and Health Equity Brigham and Women's Hospital 41 Avenue |

**Program Goals:**

| Goal Description | Goal Status | Goal Type | Time Frame |
|---|---|---|---|
| Provide financial assistance to low income, uninsured and underinsured women with breast cancer to pay for necessary services related to their breast cancer diagnosis. | In FY19, there were 23 women served by the CHAT program. | Process Goal | Year 3 of 3 |
| To provide resources to women through the CHAT program. | In FY19, 72% of CHAT participants were provided resources. Of those clients, 32% were provided with two or more resources. The majority of resources provided were for Mastectomy bras, breast prosthesis and wigs. | Outcome Goal | Year 3 of 3 |

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|---|---|
| **EOHHS Focus Issues** | Chronic Disease with focus on Cancer, Heart Disease, and Diabetes, |
| **DoN Health Priorities** | Social Environment, |
| **Health Issues** | Cancer-Breast, Social Determinants of Health-Access to Health Care, Social Determinants of Health-Uninsured/Underinsured, |
| **Target Populations** | • **Regions Served:** Boston-Greater,<br>• **Environments Served:** All,<br>• **Gender:** Female,<br>• **Age Group:** Adults,<br>• **Race/Ethnicity:** All,<br>• **Language:** All,<br>• **Additional Target Population Status:** Not Specified |

**Partners:**

| Partner Name and Description | Partner Website |
|---|---|
| Not Specified | Not Specified |

## Brigham and Women's Hospital Department of Dermatology Community Engagement

| | |
|---|---|
| **Program Type** | Community-Clinical Linkages |
| **Program is part of a grant or funding provided to an outside organization** | No |
| **Program Description** | The BWH Department of Dermatology is committed to screening and educating the underserved at risk population in Boston and surrounding communities through skin cancer screenings and screening events. |

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| **Program Hashtags** | Community Education, Health Screening, Prevention, |
| **Program Contact Information** | Heather Wilder, Administrator, Department of Dermatology, Brigham and Women's Hospital, 41 Avenue Louis Pasteur, Boston, MA 02115 |

**Program Goals:**

| Goal Description | Goal Status | Goal Type | Time Frame |
|---|---|---|---|
| Provide skin cancer screenings for underserved at risk populations in Boston and surrounding communities. | In FY19, the department provided 17 skin cancer screening events and screened 766 people. | Outcome Goal | Year 3 of 3 |
| Engage faculty and staff in skin cancer screening events. | In FY19, 18 faculty and 48 staff volunteered at skin cancer screening events. This amounted to a total of 67 screening hours and 71 education hours. | Process Goal | Year 3 of 3 |

| | |
|---|---|
| **EOHHS Focus Issues** | Chronic Disease with focus on Cancer, Heart Disease, and Diabetes, |
| **DoN Health Priorities** | Education, |
| **Health Issues** | Cancer-Skin, Social Determinants of Health-Access to Health Care, |
| **Target Populations** | • **Regions Served:** Boston-Greater,<br>• **Environments Served:** All,<br>• **Gender:** All,<br>• **Age Group:** All,<br>• **Race/Ethnicity:** All,<br>• **Language:** All,<br>• **Additional Target Population Status:** Not Specified |

**Partners:**

| Partner Name and Description | Partner Website |
|---|---|
| Dana-Farber's Sun Safety/Skin Cancer Prevention Program | https://www.dana-farber.org/about-us/community-outreach/sun-safety-skin-cancer-prevention/ |

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## Elementary School Literacy Initiative

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|---|---|
| **Program Type** | Total Population or Community-Wide Interventions |
| **Program is part of a grant or funding provided to an outside organization** | No |
| **Program Description** | The Elementary School Literacy Initiative is designed to help strengthen reading, comprehension, listening and writing skills in kindergarten to third grade students in select Mission Hill schools. Literacy skills are vital for the healthy development of children and a crucial building block for future academic success. Educational attainment is a key social determinant of health. The program provides an opportunity for Brigham and Women's Hospital (BWH) employees to volunteer directly in the schools as Pen Pals or Brigham Book Buddies. Pen Pals develop a relationship with a child through the exchange of letters. Students are able to practice their literacy skills by receiving and responding to letters and increase their exposure to health care careers and BWH. Book Buddies read aloud to an entire classroom once a month for the school year, and then the books are donated to the classroom. In FY19, 93 Pen Pal students were served, and 108 Brigham Book Buddy students were served. Since inception of the Book Buddy program in 1994, numerous students have been served, with 1,731 students served since 2006. Since its inception in 2006, the Pen Pal program has served 1,897 students. |
| **Program Hashtags** | Community Education, Mentorship/Career Training/Internship, |
| **Program Contact Information** | Pamela Audeh, Center for Community Health and Health Equity, Brigham and Women's Hospital, 41 Avenue Louis Pasteur, Boston, MA 02115 |

**Program Goals:**

| Goal Description | Goal Status | Goal Type | Time Frame |
|---|---|---|---|

| | | | |
|---|---|---|---|
| Strengthen reading, comprehension, listening and writing skills in kindergarten to fifth grade students. | In FY19, 93 Pen Pal students were served, and 108 Brigham Book Buddy students were served. | Process Goal | Year 3 of 3 |
| Partner with Mission Hill elementary schools to enhance students' academic success. | In FY19, teachers reported excellent benefits of the program in support of their students' literacy skills. Teachers also reported increased writing proficiency and listening skills among participating students. | Outcome Goal | Year 3 of 3 |
| To create enthusiasm around literacy in elementary school students. | In FY19, 100% of teachers involved with the Pen Pal and Brigham Book Buddy Program reported increased enthusiasm for reading and writing among their students. | Outcome Goal | Year 3 of 3 |

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|---|---|
| **EOHHS Focus Issues** | N/A, |
| **DoN Health Priorities** | Education, |
| **Health Issues** | Social Determinants of Health-Education/Learning, Social Determinants of Health-Language/Literacy, |
| **Target Populations** | • **Regions Served:** Boston-Mission Hill,<br>• **Environments Served:** Urban,<br>• **Gender:** All,<br>• **Age Group:** Children,<br>• **Race/Ethnicity:** All,<br>• **Language:** All,<br>• **Additional Target Population Status:** Not Specified |

**Partners:**

| Partner Name and Description | Partner Website |
|---|---|
| Maurice J. Tobin School | http://www.bostonpublicschools.org/node/524 |
| Mission Grammar School | http://www.missiongrammar.org/ |

## Health Equity Research and Intervention (HERI)

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|---|---|
| **Program Type** | Total Population or Community-Wide Interventions |
| **Program is part of a grant or funding provided to an outside organization** | No |
| **Program Description** | The Health Equity Research and Intervention team performs social determinants of health research and collaborates with individuals, institutions and communities to contribute the best science, evidence, and resources toward eliminating inequities in health status for diverse groups. HERI disseminates research findings to ensure that individuals, institutions, and communities have information resources that support their work in promoting health equity. HERI also provides support and assistance to build the capacity of colleagues and collaborators in health equity research and practice. This includes collaborative fundraising, providing networking opportunities, and participating in training of interested parties in the conduct of health equity research. |
| **Program Hashtags** | Health Professional/Staff Training, Mentorship/Career Training/Internship, Research, |
| **Program Contact Information** | Cheryl R. Clark MD, ScD / Mark Ommerborn MPH, Center for Community Health and Health Equity, Brigham & Women's Hospital, 41 Avenue Louis Pasteur |

**Program Goals:**

| Goal Description | Goal Status | Goal Type | Time Frame |
|---|---|---|---|
| Advance the goal of reducing health disparities through scientific publication on health equity topics. | In FY19, the HERI team submitted a paper for publication that examined the use of data science and machine learning for promoting health equity in self-rated health using a large public health dataset, the Behavioral Risk Factor Surveillance System. | Process Goal | Year 3 of 3 |
| Building new partnerships for community engagement. | In FY19, continued partnerships with the Roxbury Tenants of Harvard, and the Mission Hill Senior Legacy Project organization for community needs assessment and program development. | Process Goal | Year 3 of 3 |

| | | | |
|---|---|---|---|
| Supporting dissemination of health equity research and best practices. | In FY19, partnered with the Social Interventions Research & Evaluation Network (SIREN) at the University of California San Francisco and Academy Health in Washington D.C. to describe methods for screening and referring patients for health-related social needs intervention. | Outcome Goal | Year 3 of 3 |
| Supporting dissemination of health equity research and best practices. | In FY19, the HERI team launched the Leadership for Health Equity Internal Medicine Residency Pathway, to train internal medicine residents in health equity promotion. | Process Goal | Year 3 of 3 |
| Supporting dissemination of health equity research and best practices. | In FY19, continued supporting and mentoring medical residents in the Division of General Internal Medicine to develop and implement health disparity research projects. | Process Goal | Year 3 of 3 |
| Supporting dissemination of health equity research and best practices. | In FY19, presented to clinicians on how to integrate health equity and social determinants of health lenses into clinical practice at the BWH July 2019 Internal Medicine Review Course: Health Equity Research in Practice. | Outcome Goal | Year 3 of 3 |

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|---|---|
| **EOHHS Focus Issues** | Chronic Disease with focus on Cancer, Heart Disease, and Diabetes, |
| **DoN Health Priorities** | Social Environment, |
| **Health Issues** | Cancer-Breast, Cancer-Cervical, Chronic Disease-Cardiac Disease, Chronic Disease-Overweight and Obesity, Social Determinants of Health-Access to Health Care, Social Determinants of Health-Access to Healthy Food, Social Determinants of Health-Access to Transportation, Social Determinants of Health-Affordable Housing, Social Determinants of Health-Domestic Violence, Social Determinants of Health-Education/Learning, Social Determinants of Health-Environmental Quality, Social Determinants of Health-Homelessness, Social Determinants of Health-Income and Poverty, Social Determinants of Health-Language/Literacy, Social Determinants of Health-Nutrition, Social Determinants of Health-Public Safety, Social Determinants of Health-Racism and Discrimination, Social Determinants of Health-Uninsured/Underinsured, Social Determinants of Health-Violence and Trauma, |
| **Target Populations** | • **Regions Served:** Boston,<br>• **Environments Served:** Urban,<br>• **Gender:** All,<br>• **Age Group:** All,<br>• **Race/Ethnicity:** All,<br>• **Language:** All,<br>• **Additional Target Population Status:** Not Specified |

**Partners:**

| Partner Name and Description | Partner Website |
|---|---|
| Brookside Community Health Center | http://www.brighamandwomens.org/Departments_and_Services/medicine/services/primarycare/brookside/default.aspx |
| Mission Hill Senior Legacy Project | https://www.youtube.com/watch?v=7v-ERAAG-Po |
| Roxbury Tenants of Harvard | http://www.roxburytenants.org/ |
| University of California San Francisco: Social Interventions Research & Evaluation Network | https://sirenetwork.ucsf.edu/ |

## Indian Health Service

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|---|---|
| **Program Type** | Direct Clinical Services |
| **Program is part of a grant or funding provided to an outside organization** | No |
| **Program Description** | The BWH Physicians' Council, through its Brigham and Women's Outreach Programs (BWOP), is committed to supporting BWH physicians in contributing their skills and time through volunteerism. The goals of the Outreach Program include the development of a program that enables BWH physicians to directly support and enhance patient care delivered at a selected program site, while providing a sustainable, ongoing contribution to supporting an underserved community. The Indian Health Service (IHS) provides volunteer opportunities for BWH physicians at the IHS hospitals in Gallup and Shiprock, New Mexico and an IHS hospital in Chinle, Arizona. All sites serve American Indian communities in remote rural locations. The hospital in Shiprock is located on the Navajo reservation. The 55-bed hospital at Shiprock, 99-bed hospital at Gallup and 60-bed hospital in Chinle have adequate equipment, medication and supplies, but they are challenged by a shortage of staffing. The Indian Health Service reports a nearly 15 percent vacancy rate in essential clinical positions, including access to specialty services and consultations. The BWOP physician volunteers are working to address this challenge. In addition to health professionals volunteering on-site in New Mexico and Arizona, physicians led educational and remote-teaching video and audio conferences broadcast to IHS clinical colleagues at these sites and IHS clinicians were hosted at BWH. From 2008 through 2019, Brigham Health volunteer clinicians have made 273 on-site visits, led 228 remote-teaching video and audio conferences and hosted 21 IHS clinicians at BWH. |
| **Program Hashtags** | Community Health Center Partnership, Health Professional/Staff Training, |
| **Program Contact Information** | Thomas Sequist, MD, Brigham & Women's Hospital, 617-525-7509. |

**Program Goals:**

| Goal Description | Goal Status | Goal Type | Time Frame |
|---|---|---|---|
| Provide volunteer opportunities for BWH physicians at the IHS hospitals in Gallup and Shiprock, New Mexico and Chinle, Arizona. | In FY19, 28 faculty clinicians and professional staff (plus 1 physician-in-training) made 32 volunteer site-visits to the IHS hospitals in New Mexico and Arizona. | Outcome Goal | Year 3 of 3 |
| Provide volunteer opportunities for BWH physicians to lead Boston-based educational and teaching video conferences to IHS clinician colleagues to expand their capacity to treat a range of conditions. | In FY19, 32 physician and professional staff volunteers led 40 remote teaching video and audio conferences. | Outcome Goal | Year 3 of 3 |

| | |
|---|---|
| **EOHHS Focus Issues** | Chronic Disease with focus on Cancer, Heart Disease, and Diabetes, |
| **DoN Health Priorities** | Education, Social Environment, |
| **Health Issues** | Cancer-Other, Chronic Disease-Arthritis, Chronic Disease-Asthma/Allergies, Chronic Disease-Cardiac Disease, Chronic Disease-Chronic Pain, Chronic Disease-Diabetes, Chronic Disease-Hypertension, Chronic Disease-Osteoporosis, Chronic Disease-Overweight and Obesity, Chronic Disease-Pulmonary Disease, Chronic Disease-Stroke, Health Behaviors/Mental Health-Depression, Health Behaviors/Mental Health-Mental Health, Health Behaviors/Mental Health-Stress Management, Infectious Disease-HIV/AIDS, Injury-Sports Injuries, Maternal/Child Health-Family Planning, Maternal/Child Health-Reproductive and Maternal Health, Other-Dental Health, Social Determinants of Health-Access to Health Care, Social Determinants of Health-Violence and Trauma, Substance Addiction-Alcohol Use, Substance Addiction-Smoking/Tobacco Use, Substance Addiction-Substance Use, |
| **Target Populations** | • **Regions Served:** Not Specified<br>• **Environments Served:** Rural,<br>• **Gender:** All,<br>• **Age Group:** All,<br>• **Race/Ethnicity:** American Indian/Alaskan Native,<br>• **Language:** All,<br>• **Additional Target Population Status:** Not Specified |

**Partners:**

| Partner Name and Description | Partner Website |
|---|---|
| Chinle Comprehensive Regional Health Care Facility | http://www.ihs.gov/Navajo/index.cfm?module=nao_hcc_chinle |
| Gallup Indian Medical Center | http://www.ihs.gov/navajo/index.cfm?module=nao_hcc_gallup |
| Northern Navajo Medical Center | http://www.ihs.gov/navajo/index.cfm?module=nao_hcc_shiprock |

## Partnership with Kennedy Academy for Health Careers (formerly Health Careers Academy)

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|---|---|
| **Program Type** | Total Population or Community-Wide Interventions |
| **Program is part of a grant or funding provided to an outside organization** | Yes |
| **Program Description** | In FY19, BWH provided grant support to the Health Careers Engagement project at Edward M. Kennedy Academy for Health Careers (EMK), a Horace Mann Charter School that prepares students in the ninth through twelfth grades for careers in the health sciences. The goals of the Health Careers Engagement project are to promote student knowledge of health care professions, increase the number of students who enter college programs designed to prepare them for health careers, and expand the number and variety of internships and other workplace learning experiences that are available to Kennedy Academy students. In FY19, 383 youth in grades 9-12 participated. Since Inception, 2097 youth have participated. |
| **Program Hashtags** | Community Education, Mentorship/Career Training/Internship, |
| **Program Contact Information** | Bill Rawlinson, Health Engagement Coordinator Edward M. Kennedy Academy for Health Careers 360 Huntington Avenue-102 Cahners Hall Boston, MA 02115 |

**Program Goals:**

| Goal Description | Goal Status | Goal Type | Time Frame |
|---|---|---|---|
| A primary goal of the Health Careers Engagement work is to connect EMK students to a variety of mission-related internships, enrichment programs and paid work experiences both within and outside of school. | During the 2018 - 2019 School Year, EMK's Health Engagement Coordinator guided students toward competitive academic, youth development, and health-related extracurricular engagements - both during the school year and in the summer. Partners included Brigham and Women's Hospital, Massachusetts General Hospital, Children's Hospital, Hebrew Senior Life, Mass Eye & Ear, Vertex Pharmaceuticals, Boston Area Health Education Center (BAHEC), Project Teach, Summer Search, Optum, Blue Cross Blue Shield and the Harvard MedScience Program. As a result, 214 students participated in health and/or academic support related out of school programming. Highlights included:<br>- All 10th Grade students as part of their Health Assisting classes participated in the 12-week Harvard MedScience Program. This highly recognized program utilizes real life medical situations and equipment as the delivery method to teach body systems, processes and scenarios experienced in hospitals and to cultivate interest in a variety of healthcare-related careers. Participating students learn to take and read vital signs, interpret x-rays and lab reports, intubate patients, set IV's and perform other procedures common to a healthcare setting.<br>- Forty-seven 11th & 12th Graders participated in a year-long clinical experience at Hebrew Senior Life, getting first hand exposure to patient care and treatment. | Outcome Goal | Year 3 of 3 |
| A primary goal of the Health Careers Engagement work is to connect EMK students with health professionals as visitors to EMK classrooms to share information about their career field, their career path, and the course of study required. | 42 health/STEM-related professionals and students from 10 organizations provided classroom guest speakers from the healthcare industry and related fields for grades 9-12, presenting on different health disciplines and health topics, sharing stories with students about their professional journeys and in some cases providing academic support. | Outcome Goal | Year 3 of 3 |
| | During the 2018 - 2019 school year, visits to healthcare and related industry sites throughout Boston were coordinated for a total of three site visits for students in grade 9, three site visits | | |

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|---|---|---|---|
| A primary goal of the Health Careers Engagement project is to allow EMK students to visit community-based health care sites to observe and experience the wide range of career paths first hand. | for students in grade 10, and 4 site visits for students in grades 11 and 12 (276 students total). Partners in these visits included the Forsyth Dental School at Mass College of Pharmacy and Health Sciences, Northeastern University, MIT, Harvard University, Harvard Medical School, Harvard MedScience Simulation Lab, Harvard School of Public Health and the American College of Surgeons National Conference among others.<br>Healthcare/STEM related job shadow experiences were coordinated for 21 Grade 10 students at MGH, Accenture and the Federal Reserve Bank. | Outcome Goal | Year 3 of 3 |
| A primary goal of the health careers engagement project is to encourage EMK students to select a health-related major in their pursuit of higher education. | The 2018 - 2019 school year saw the first year of full engagement of EMK students in the Health Assisting CTE pathway for EMK upperclassmen. Ninth & Tenth Grade students continued their exposure and foundational skills/knowledge building in their academic classes, 24 11th Grade students began their clinical duties at Hebrew Senior Life in Roslindale, while 23 12th Grade students completed their clinical program, culminating in testing for their CNA credential. The experience for all involved continues to be a tremendous success. HSL staff and patients were extremely impressed with and connected to the EMK students; EMK students enjoyed the professional exposure and became accepted as part of the HSL family; and the teacher, with previous experience in a clinical setting with CTE students, claimed it was the best she has ever been a part of. Further connections between EMK and HSL are being explored for next year, including employment opportunities for students. As referenced above, all 10th grade students participated in the Harvard MedScience program, exposing them to real-life medical scenarios and the various careers and educational paths that relate.<br>All 9th Grade students as part of their health classes were trained by school staff and visiting health care professionals to take and read an individual's vital signs and understand the information relating to them. In November, the 2nd Annual EMK Vital Signs day was held, where over the 70 "patients" from our partners were checked and educated by the 9th Graders on healthy living and their vital signs. | Outcome Goal | Year 3 of 3 |

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|---|---|
| **EOHHS Focus Issues** | N/A, |
| **DoN Health Priorities** | Education, Employment, Social Environment, |
| **Health Issues** | Social Determinants of Health-Education/Learning, Social Determinants of Health-Language/Literacy, |
| **Target Populations** | • **Regions Served:** Boston,<br>• **Environments Served:** Urban,<br>• **Gender:** All,<br>• **Age Group:** Teenagers,<br>• **Race/Ethnicity:** All,<br>• **Language:** All,<br>• **Additional Target Population Status:** Not Specified |

**Partners:**

| Partner Name and Description | Partner Website |
|---|---|
| Boston GLASS | http://jri.org/services/health-and-housing/health/boston-glass |
| Boston Private Industry Council | http://www.bostonpic.org/ |
| Boston University School of Public Health | http://sph.bu.edu/ |
| Bouve College of Health Science | http://www.northeastern.edu/bouve/ |
| Brigham & Women's Hospital | http://www.brighamandwomens.org/ |
| Bunker Hill Community College | http://www.bhcc.mass.edu/ |
| Center for Community Health | http://www.cchers.org/ |

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| Education Research and Service (CCHERS) | |
| Harvard Medical School | http://www.hms.harvard.edu/ |
| Harvard School of Public Health | http://www.hsph.harvard.edu/ |
| Massachusetts College of Pharmacy & Health Sciences | https://www.mcphs.edu/ |
| Massachusetts General Hospital | http://www.massgeneral.org/ |
| Northeastern University | http://www.northeastern.edu/ |
| Simmons College | http://www.simmons.edu/ |
| Wentworth Institute of Technology | http://www.wit.edu/ |
| Biogen Community Lab | https://www.biogen.com/en_us/responsibility/community-lab.html |
| The Samaritans | http://www.samaritans.org/ |
| New England College of Optometry | www.neco.edu |
| UMass - Boston; Nursing | http:// www.umb.edu/ |
| Harvard MedScience | http://www. hmsmedscience.org |
| Vertex Pharmaceuticals | https://www.vrtx.com/ |
| YMCA Huntington Avenue | https:// ymcaboston.org/huntington |
| Hebrew Senior Life | http:// www.hebrewseniorlife.org |

## Project TEACH (Teen Education About Careers in Health)

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|---|---|
| **Program Type** | Total Population or Community-Wide Interventions |
| **Program is part of a grant or funding provided to an outside organization** | No |
| **Program Description** | Project TEACH (Teen Education About Careers in Health) is a summer program targeted at rising 10th grade students attending BWH partnering public high schools in the surrounding neighborhoods. The program is designed to stimulate interest in health, science and medical careers. In FY19, 25 youth participated. Since inception in 2009, 247 students have participated. |
| **Program Hashtags** | Community Education, Mentorship/Career Training/Internship, |
| **Program Contact Information** | Jesenia Cortes, SSJP Coordinator, Center for Community Health and Health Equity, Brigham and Womenâ€™s Hospital |

**Program Goals:**

| Goal Description | Goal Status | Goal Type | Time Frame |
|---|---|---|---|
| Expose rising 10th grade students to a variety of professions in health and science in order to stimulate interest in the field. | Project TEACH students are provided with a paid internship for 24 hours per week for six weeks in BWH departments. In FY19, 25 students participated; since inception in 2009, 247 students have participated. Evaluation results show that 88% of FY19 participants reported a positive change in critical thinking, and 75% showed positive change in growth mindset, reflection, and perseverance as a result of the program. | Outcome Goal | Year 3 of 3 |
| Prepare rising 10th grade students for high school math and science courses. | In FY19, Project TEACH provided teaching, support, guidance in preparing research papers and presentations on science or health topics of students' choosing. Students participated in weekly science related field trips as well as college tours. | Process Goal | Year 3 of 3 |
| Strengthen the pipeline between our middle school and high school youth programs. | In FY19, 11 Summer Science Academy Alumni from Summer 2018 applied to Project TEACH, and all were accepted. | Outcome Goal | Year 3 of 3 |
| Strengthen the pipeline between our middle school and high school youth programs. | In addition, 24 Project TEACH Alumni from Summer 2019 applied to Student Success Jobs Program in the autumn of 2019 and all were accepted. | Outcome Goal | Year 3 of 3 |

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| Provide students with summer work experience in a hospital setting with highly skilled health care professionals as their supervisors. | In FY19, 18 BWH health professionals were recruited to advance learning and exposure of health, science and medical careers to participating rising 10th grade students in Project TEACH. | Process Goal | Year 3 of 3 |

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| **EOHHS Focus Issues** | N/A, |
| **DoN Health Priorities** | Education, Employment, Social Environment, |
| **Health Issues** | Social Determinants of Health-Education/Learning, Social Determinants of Health-Language/Literacy, |
| **Target Populations** | • **Regions Served:** Boston,<br>• **Environments Served:** All,<br>• **Gender:** All,<br>• **Age Group:** Child-Teen,<br>• **Race/Ethnicity:** All,<br>• **Language:** All,<br>• **Additional Target Population Status:** Not Specified |

**Partners:**

| Partner Name and Description | Partner Website |
|---|---|
| Boston Private Industry Council | http://www.bostonpic.org/ |
| Boston Latin Academy | http://latinacademy.org/ |
| Community Academy of Science and Health | http://www.bostonpublicschools.org/node/416 |
| Edward M. Kennedy Academy for Health Careers | http://www.kennedyacademy.org/ |
| Urban Science Academy | http://www.urbansci.com/ |
| Madison Park Technical Vocational High School | http://www.madisonparkhs.org/ |

## Racial Reconciliation and Healing Project

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| **Program Type** | Total Population or Community-Wide Interventions |
| **Program is part of a grant or funding provided to an outside organization** | No |
| **Program Description** | As an approach to improving community health, the Southern Jamaica Plain Health Center, a licensed health center of BWH is working with a group of 16 youth (8 white youth and 8 youth of color) in a racial reconciliation and healing (RRH) process. Through readings, affinity groups, workshops, speak outs and community teaching, youth are challenged and supported to understand the levels of the system of racism, explore racial identity development theory, and transform into racial justice activists, channeling their efforts to address the impact of racism on the social determinants of health with a focus on employment, workforce development and education. The RRH framework and activities are now being used across public health systems locally and nationally and with medical professionals in Boston and Cambridge. |
| **Program Hashtags** | Community Education, Prevention, |
| **Program Contact Information** | Abigail Ortiz, MSW, MPH, Co-Director, Racial Justice and Equity Initiatives, Southern Jamaica Plain Health Center, 640 Centre Street, Jamaica Plain, M |

**Program Goals:**

| Goal Description | Goal Status | Goal Type | Time Frame |
|---|---|---|---|
| Train youth in health equity, racial justice framing, basic public health and epidemiology and undoing racism work | 16 youth completed trainings in June 2019. | Process Goal | Year 3 of 3 |
| Train adults in the RRH Model started in 2012 | 5 faculty trainees completed in June 2019; 30 adults were trained. | Process Goal | Year 3 of 3 |

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| Provide community education health equity and the community connection between racism and health | Within a 12-month period, the RRH team provided 7 trainings for their peers at schools and recruitment events. These trainings were completed in June 2019. | Outcome Goal | Year 3 of 3 |
| Connect work of R&R team with larger Jamaica Plain Equity | Monthly trainings have been offered to community members since December 2011, with over 2,500, individuals trained as of FY19. Key aspects of RRH model being used by Human Impact Partners in Oakland, Department of Public Health, MA, and with a variety of racial justice and equity focused initiatives at BWH, Cambridge Health Alliance and Boston Medical Center. | Outcome Goal | Year 3 of 3 |
| Maintain and expand website | New content added monthly to www.racialrec.org with over 200 resource downloads in FY19. | Process Goal | Year 3 of 3 |

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| **EOHHS Focus Issues** | N/A, |
| **DoN Health Priorities** | Built Environment, Education, Social Environment, |
| **Health Issues** | Social Determinants of Health-Access to Health Care, Social Determinants of Health-Access to Healthy Food, Social Determinants of Health-Access to Transportation, Social Determinants of Health-Affordable Housing, Social Determinants of Health-Domestic Violence, Social Determinants of Health-Education/Learning, Social Determinants of Health-Environmental Quality, Social Determinants of Health-Homelessness, Social Determinants of Health-Income and Poverty, Social Determinants of Health-Language/Literacy, Social Determinants of Health-Nutrition, Social Determinants of Health-Public Safety, Social Determinants of Health-Racism and Discrimination, Social Determinants of Health-Uninsured/Underinsured, Social Determinants of Health-Violence and Trauma, |
| **Target Populations** | • **Regions Served:** Not Specified<br>• **Environments Served:** Not Specified<br>• **Gender:** Not Specified<br>• **Age Group:** Not Specified<br>• **Race/Ethnicity:** Not Specified<br>• **Language:** Not Specified<br>• **Additional Target Population Status:** Not Specified |

**Partners:**

| Partner Name and Description | Partner Website |
|---|---|
| Boston Public Health Commission | www.bphc.org |
| The City School Summer Leadership Program | http://thecityschool.org |
| Brookline High School | http://bhs.brookline.k12.ma.us/ |
| Boston Latin School | http://www.bls.org/ |
| Boston Latin Academy | http://latinacademy.org/ |
| Meridian Academy | http://www.meridianacademy.org/ |
| City on the Hill | http://www.cityonahill.org |
| English High School | http://www.englishhs.org/ |
| Milton Academy | http://milton.edu/ |
| Brimmer and May | https://www.brimmer.org/ |

## South Street Youth Center

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| **Program Type** | Total Population or Community-Wide Interventions |
| **Program is part of a grant or funding provided to an outside organization** | Yes |
| **Program Description** | BWH provides a financial contribution to the operation of the South Street Youth Center (SSYC) whose mission is to provide a safe, educational, and engaging space during out-of-school time for young residents of South Street Development. Through its broad-based programs, participants learn a happy, healthy, resilient attitude toward life that will help sustain them through adulthood. In FY19, 132 youth accessed the Center. Since inception, approximately 700 youth have accessed SSYC. |

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| **Program Hashtags** | Community Education, |
| **Program Contact Information** | Corey Stallings, Program Coordinator, South Street Youth Center, South Street Development, 617-477-8263 |

**Program Goals:**

| Goal Description | Goal Status | Goal Type | Time Frame |
|---|---|---|---|
| Provide a safe, educational, and engaging space during out of school time for young residents of South Street Development in Jamaica Plain. | In FY19, 132 youth participated in SSYC. Since inception approximately 700 youth accessed SSYC. | Process Goal | Year 3 of 3 |
| Maintain youth attendance rates in programming. | In FY19, the average daily attendance at the Center was 51 individuals. The new teen and youth programs have increased engagement with our youth and programs have flourished. An increase from 31 to 35 on average. | Outcome Goal | Year 3 of 3 |
| Maintain percentage of youth accessing SSYC as a resource for homework help during after-school. | In FY19, 100% of youth reported doing homework during homework time. There is a robust homework support team and we have welcomed the addition of a partnership with Brookline High School that has increased volunteers/interns at our program with a focus on social justice. | Outcome Goal | Year 3 of 3 |
| Maintain percentage of teens accessing SSYC as a resource for employment/education assistance. | In FY19, 35 youth received employment assistance and 40 received educational assistance. SSYC also had its 5th Annual College Tour and we had a 100% graduation rate from our senior class. Our entrepreneurial program has grown over the past year with new partnerships with local businesses as well as a t-shirt program in development. Between CPC's, IA's, Summer mentors, BCYF and ABCD (2 cycles - winter & spring), there were 47 total youth employed this past year. | Outcome Goal | Year 3 of 3 |

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| **EOHHS Focus Issues** | N/A, |
| **DoN Health Priorities** | Education, Employment, Social Environment, |
| **Health Issues** | Social Determinants of Health-Education/Learning, Social Determinants of Health-Income and Poverty, Social Determinants of Health-Language/Literacy, |
| **Target Populations** | • **Regions Served:** Boston-Jamaica Plain,<br>• **Environments Served:** Urban,<br>• **Gender:** All,<br>• **Age Group:** Child-Preteen, Child-Primary School, Child-Teen,<br>• **Race/Ethnicity:** All,<br>• **Language:** English, Spanish,<br>• **Additional Target Population Status:** Not Specified |

**Partners:**

| Partner Name and Description | Partner Website |
|---|---|
| BPD E-13 Community Service department | http://www.bpdnews.com/districts/e-13/e-13- community-service-office/ |
| Boston Housing Authority | http://www.bostonhousing.org |
| Jamaica Plain Neighborhood Housing Corporation | http://www.jpndc.org |
| Spontaneous Celebration/ Beantown Society | http://www.spontaneouscelebrations.org/mission.html |
| Curtis Hall/BCYF | http://jpcommunitycenters.org/programs/curtis-hall-programs/ |
| The Mildred Hailey | http://www.bostonhousing.org |
| ADOBE Youth Voices | http://www.adobe.com/corporate-responsibility/education/adobe-youth-voices.html |
| ABCD SummerWorks | http://www.bostonabcd.org/programs/youth- development/summer-works/index.html |
| Linda Wellness Warrior | Lindawellnesswarrior.com |

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| Eliot School | http://eliotschool.org |
| Arbour Hospital | http://arbourhealth.com/organizations/arbour-hospital |
| First Baptist Church | http://www.firstbaptistjp.org/default.asp?sec_id=18 001020 |
| Bromley Heath Task Force | Not Specified |
| City Real Estate | Not Specified |
| Ferris Wheels | http://ferriswheelsbikeshop.com/ |
| State Rep. Liz Maliaâ€™s Office | http://www.malegislature.gov/People/Profile/eam1 |
| Cooperative Artists Institute | http://www.tribal-rhythms.org/ |
| Southern Jamaica Plain Health Center | http://www.brighamandwomens.org/Departments_and_Services/medicine/services/primarycare/sjphc |
| Tree of Life/Arbol de Vida | Not Specified |
| Friends of South Street | Not Specified |

## Southern Jamaica Plain Health Center (SJPHC)

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|---|---|
| **Program Type** | Direct Clinical Services |
| **Program is part of a grant or funding provided to an outside organization** | No |
| **Program Description** | Southern Jamaica Plain Health Center (SJPHC) operates through the license of Brigham and Women's Hospital and has been serving the community for 46 years. SJPHC's mission is to provide personal, high quality health care with compassion and respect to a diverse community. The health center now serves over 10,000 patients with its comprehensive services of adult medicine, pediatrics, women's health, mental health/substance abuse services, cardiology, nutrition, and podiatry. Health center providers include seven internists, four pediatricians, two internists/pediatricians, two physician assistants, an obstetrician/gynecologist, midwives and nurse practitioners in women's health, a podiatrist, renal specialist and cardiologist, and social workers, psychologists and psychiatrists in the mental health/substance abuse department. A bilingual staff of nurses, medical assistants, administrative staff, financial counselors, and other staff provide services and support the work of medical providers. The health center augments its medical and mental health services with health education, case management, screening programs (blood pressure, diabetes, mammography, cholesterol), and a Health Promotion Center that provides exercise, health education, support groups and other programming to patients and community. In addition, the health center has a long history of providing substance abuse treatment services to patients, families, and the community. Health center staff also work collaboratively with residents of the local South Street public housing development to promote the health of public housing residents. In FY19, 10,252 patients completed 40,899 visits. |
| **Program Hashtags** | Community Education, Health Screening, Prevention, |
| **Program Contact Information** | Tom Kieffer, Executive Director, Southern Jamaica Plain Health Center, 640 Centre Street, Jamaica Plain, MA 02130 |

**Program Goals:**

| Goal Description | Goal Status | Goal Type | Time Frame |
|---|---|---|---|
| Provide personal, high quality health care with compassion and respect to a diverse community. | In FY19, 10,252 patients were served. | Process Goal | Year 3 of 3 |
| Operate a Health Promotion Center to provide more alternative and complementary health services. | In FY19, the Health Promotion Center (HPC) continued to provide multiple movement programs, senior programs, and youth programs. Over 1,000 patients and residents participated in HPC programs. | Outcome Goal | Year 3 of 3 |
| Expand group visits. | In FY19, mental health groups continued to meet on a weekly basis, covering different topics each week. Total attendance increased by 5% from 636 attendees in FY18 to 667 attendees in FY19. | Outcome Goal | Year 3 of 3 |
| Maintain status as a Patient Centered Medical Home | Southern Jamaica Plain Health Center remains certified as a Patient Centered Medical Home. | Outcome Goal | Year 3 of 3 |

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| **EOHHS Focus Issues** | Chronic Disease with focus on Cancer, Heart Disease, and Diabetes, Housing Stability/Homelessness, Mental Illness and Mental Health, Substance Use Disorders, |
| **DoN Health Priorities** | Education, Social Environment, |
| **Health Issues** | Cancer-Breast, Cancer-Cervical, Cancer-Colorectal, Cancer-Lung, Cancer-Multiple Myeloma, Cancer-Other, Cancer-Ovarian, Cancer-Prostate, Cancer-Skin, Chronic Disease-Alzheimer's Disease, Chronic Disease-Arthritis, Chronic Disease-Asthma/Allergies, Chronic Disease-Cardiac Disease, Chronic Disease-Chronic Pain, Chronic Disease-Colitis/Crohn's Disease, Chronic Disease-Diabetes, Chronic Disease-Hypertension, Chronic Disease-Osteoporosis, Chronic Disease-Overweight and Obesity, Chronic Disease-Pulmonary Disease, Chronic Disease-Sickle Cell Disease, Chronic Disease-Stroke, Health Behaviors/Mental Health-Bereavement, Health Behaviors/Mental Health-Depression, Health Behaviors/Mental Health-Immunization, Health Behaviors/Mental Health-Mental Health, Health Behaviors/Mental Health-Physical Activity, Health Behaviors/Mental Health-Responsible Sexual Behavior, Health Behaviors/Mental Health-Stress Management, Infectious Disease-Hepatitis, Infectious Disease-HIV/AIDS, Infectious Disease-Lyme Disease, Infectious Disease-Sexually Transmitted Diseases, Infectious Disease-Tuberculosis, Injury-Auto/Passenger Injuries, Injury-First Aid/ACLS/CPR, Injury-Home Injuries, Injury-Other, Injury-Sports Injuries, Maternal/Child Health-Child Care, Maternal/Child Health-Family Planning, Maternal/Child Health-Menopause, Maternal/Child Health-Parenting Skills, Maternal/Child Health-Reproductive and Maternal Health, Other-Cultural Competency, Other-Dental Health, Other-Emergency Preparedness, Other-Hearing, Other-Senior Health Challenges/Care Coordination, Other-Vision, Social Determinants of Health-Access to Health Care, Social Determinants of Health-Access to Healthy Food, Social Determinants of Health-Access to Transportation, Social Determinants of Health-Affordable Housing, Social Determinants of Health-Domestic Violence, Social Determinants of Health-Education/Learning, Social Determinants of Health-Homelessness, Social Determinants of Health-Income and Poverty, Social Determinants of Health-Language/Literacy, Social Determinants of Health-Nutrition, Social Determinants of Health-Public Safety, Social Determinants of Health-Racism and Discrimination, Social Determinants of Health-Uninsured/Underinsured, Social Determinants of Health-Violence and Trauma, Substance Addiction-Alcohol Use, Substance Addiction-Driving Under the Influence, Substance Addiction-Opioid Use, Substance Addiction-Smoking/Tobacco Use, Substance Addiction-Substance Use, |
| **Target Populations** | • **Regions Served:** Boston,<br>• **Environments Served:** All,<br>• **Gender:** All,<br>• **Age Group:** All,<br>• **Race/Ethnicity:** All,<br>• **Language:** All,<br>• **Additional Target Population Status:** Not Specified |

**Partners:**

| Partner Name and Description | Partner Website |
|---|---|
| Hyde Square Task Force | http://www.hydesquare.org/ |
| JP Neighborhood Development Corp | http://www.jpndc.org/ |
| Boston Housing Authority â€" South Street | http://www.bostonhousing.org/detpages/devinfo52.html |
| Jamaica Plain Tree of Life/Arbol de Vida | Not Specified |

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## Stronger Generation Case Manager Program

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| **Program Type** | Access/Coverage Supports |
| **Program is part of a grant or funding provided to an outside organization** | Yes |
| **Program Description** | The Stronger Generations Case Manager Program seeks to improve birth outcomes by addressing the social and medical needs of pregnant women. BWH provides technical assistance and training for case managers at each of five of the hospital's licensed or affiliated health centers. In FY19, 484 women received case management services through the Stronger Generations case management program. Since inception in 1991, the case managers in the program have served over 15,750 women and families. |
| **Program Hashtags** | Community Education, Community Health Center Partnership, Prevention, |

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| **Program Contact Information** | Ariel Childs, Program Director, Stronger Generations Initiative, Center for Community Health and Health Equity Brigham and Women's Hospital 41 Avenue |

**Program Goals:**

| Goal Description | Goal Status | Goal Type | Time Frame |
|---|---|---|---|
| To identify clients in need of case management services, conduct assessment for areas of medical and social concern. | In FY19, 95% of new clients enrolled in the case management program, completed an initial assessment, which gauged baseline clinical and social risk factors. Of these, the majority of clients had high intensity needs for services such as housing, food insecurity, mental health, employment, challenges accessing health care, and community/family safety.<br>Case managers work to create supports and linkages that complement their clinical care and improve birth outcomes. | Process Goal | Year 3 of 3 |
| To improve maternal health outcomes related to pregnancy and birth by addressing patients social and medical risks that improve health outcomes across the life course. | In FY19, 80% of women referred to a case manager attended the recommended 80% of prenatal visits. There are several social risks being addressed by case managers in which, 36% of the clients are adolescent parents 25 years or younger, 20% reported not having reliable access to affordable, nutritious food, 20% reporting unmet mental health needs, and 34% reporting challenges accessing healthcare.<br><br>To meet the identified needs of our patients, case managers completed more than 400 referrals to community -based organizations for program clients. | Outcome Goal | Year 3 of 3 |
| To provide assistance with material goods to a minimum of 30 families to address the gaps in services. | In FY19, Stronger Generations Case Managers provided diapers, wipes, infant supplies including layettes, grocery food cards to over 150 clients of the case management program. | Process Goal | Year 3 of 3 |
| To provide transportation assistance to a minimum of 60 patients in BWH licensed and affiliated health centers. | In FY19, over 150 patients were provided with transportation assistance through the provision of Charlie Cards and cab vouchers through the Perinatal Transportation Assistance Program. | Process Goal | Year 3 of 3 |

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| **EOHHS Focus Issues** | N/A, |
| **DoN Health Priorities** | Education, Social Environment, |
| **Health Issues** | Maternal/Child Health-Child Care, Maternal/Child Health-Family Planning, Maternal/Child Health-Parenting Skills, Maternal/Child Health-Reproductive and Maternal Health, Social Determinants of Health-Access to Health Care, Social Determinants of Health-Access to Transportation, |
| **Target Populations** | • **Regions Served:** Boston, Boston-Jamaica Plain, Boston-Mattapan, Boston-Roxbury, Boston-South End,<br>• **Environments Served:** All,<br>• **Gender:** Female,<br>• **Age Group:** All,<br>• **Race/Ethnicity:** All,<br>• **Language:** All,<br>• **Additional Target Population Status:** Not Specified |

**Partners:**

| Partner Name and Description | Partner Website |
|---|---|
| Mattapan Community Health Center | http://www.mattapanchc.org/ |
| South End Community Health Center | http://www.sechc.org |
| Whittier Street Health Center | http://wshc.org |

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## Stronger Generations

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| **Program Type** | Community-Clinical Linkages |
| **Program is part of a grant or funding provided to an outside organization** | No |

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| **Program Description** | Stronger Generations seeks to eliminate the racial disparities in infant mortality and poor birth outcomes among the communities served by Brigham and Women's Hospital. Beyond eliminating the persistent racial and ethnic disparities in infant mortality, the Stronger Generations initiative aims to lay a foundation for a lifetime of health equity through a focus on the social, medical, and economic needs of women and their families before, during, and after their pregnancies. Working with our community partners, Stronger Generations aims to improve maternal and child outcomes by linking quality medical care and community resources to strengthen their own health, support positive parenting and give their babies the healthiest possible start. This goal is accomplished through programs including a Baby CafÃ©, Case Management Program, Infant-Child Safety Program, Centering Pregnancy and Proud 2 Parent Programs, our signature pipeline of programming for young families.<br><br>Our young parent program activities strive to address the diverse needs of the pregnant and parenting young adult population through an array of programs aimed at providing social support and reducing the stress and isolation that some young parents face. In FY19, Stronger Generations continued community outreach efforts, particularly those supporting adolescent and young adult parents, and supported the initiatives growing programmatic offerings in leadership development, workforce development, and social support. In FY19, Stronger Generations engaged a total of 398 individuals. Since inception in 2010, this effort has engaged over 6,300 individuals. |
| **Program Hashtags** | Community Education, Community Health Center Partnership, Support Group, |
| **Program Contact Information** | Ariel Childs, Program Director, Stronger Generations Initiative, Center for Community Health and Health Equity Brigham and Women's Hospital 41 Avenue |

**Program Goals:**

| Goal Description | Goal Status | Goal Type | Time Frame |
|---|---|---|---|
| To lead a Young Parent Council providing a leadership and workforce development opportunity for young parents interested in informing and guiding Proud2Parent programming, and in pursuing community outreach and advocacy for their young parent peers. | While FY19 was a program development year for both the Young Parent Ambassador Program and the Young Parent Mentoring Program, Proud2Parent efforts focused on leading a cohort of 10 young parents who joined our Young Parent Council. The council focused on leadership development, community outreach, and the planning and execution of our annual STEPS young parent summit. | Process Goal | Year 3 of 3 |
| To organize a city-wide summit for pregnant and parenting young adults. | In FY19 the Summit for Teen Empowerment & Parenting Success (STEPS) convened over 95 pregnant and parenting young adults & those who support them. In addition, over 70 providers from 40 organizations serving young families provided resources and information about their services. As a result of this event, participating organizations received 92 new young parent referrals. | Process Goal | Year 3 of 3 |
| To increase goal-setting, economic mobility, and workforce development opportunities for young parents through the Young Parent Success grants program, which provides funding for young parent programming at two partnering community-based organizations. | The Young Parent Success Grants Program worked with Mothers for Justice and Equality to provide leadership development, financial literacy and workforce development opportunities to 46 young families. The program also worked with EMPath to provide intensive economic mobility coaching to 6 young families. | Outcome Goal | Year 3 of 3 |
| To provide vulnerable/at-risk families with infant/child safety resources and information through our infant car seat program. | In FY19, distributed 33 infant car seats for families in need, and provided them with information and education related to infant/child safety. | Process Goal | Year 3 of 3 |
| To provide transportation assistance to low-income pregnant and postpartum women who experience barriers to attending medical appointments. | In FY19, provided 150 women and families with transportation assistance to attend prenatal, postpartum and pediatric medical appointments at 10 health care sites. | Process Goal | Year 3 of 3 |
| To provide Centering Pregnancy as a shared medical visit model for women receiving prenatal care at Brigham and Women's Hospital's Resident OB Ambulatory Care clinic. | In FY19, provided Centering Pregnancy prenatal care to 50 Brigham and Women's Hospital patients. | Process Goal | Year 3 of 3 |

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| To provide free community-based bi-lingual/bi-cultural breastfeeding support through trained lactation professionals to families prenatally and postpartum at Southern Jamaica Plain Health Center. | In FY19, certified lactation staff provided 88 women with breastfeeding support for families experiencing a variety of infant feeding challenges. Attendees at these cafes visited for various concerns including, infant weight gain, infant latch, pumping at the work place and milk supply. | Process Goal | Year 3 of 3 |

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|---|---|
| **EOHHS Focus Issues** | N/A, |
| **DoN Health Priorities** | Education, Employment, Social Environment, |
| **Health Issues** | Maternal/Child Health-Child Care, Maternal/Child Health-Family Planning, Maternal/Child Health-Parenting Skills, Maternal/Child Health-Reproductive and Maternal Health, Social Determinants of Health-Access to Health Care, Social Determinants of Health-Access to Transportation, Social Determinants of Health-Education/Learning, Social Determinants of Health-Income and Poverty, Social Determinants of Health-Racism and Discrimination, Social Determinants of Health-Uninsured/Underinsured, Social Determinants of Health-Violence and Trauma, |
| **Target Populations** | • **Regions Served:** Boston,<br>• **Environments Served:** All,<br>• **Gender:** All,<br>• **Age Group:** Adult-Young,<br>• **Race/Ethnicity:** Black/African American, Hispanic/Latino,<br>• **Language:** All,<br>• **Additional Target Population Status:** Not Specified |

**Partners:**

| Partner Name and Description | Partner Website |
|---|---|
| Not Specified | Not Specified |
| Jeremiah Program | https://jeremiahprogram.org/boston |
| Boston Childrenâ€™s Hospital Injury Prevention Program | http://www.childrenshospital.org/centers-and-services/programs/f-_-n/injury-prevention-program |
| Thom Boston Metro Early Intervention | https://www.thomchild.org/locations/boston-metro-early-intervention/ |
| Family Nurturing Center | https://www.familynurturing.org/ |
| ABCD Head Start & Childrenâ€™s Services | https://bostonabcd.org/service/head-start-childrens-services/ |
| ABCD Energy Services | https://bostonabcd.org/service_categories/energy/ |
| ABCD Youth Services | https://bostonabcd.org/service_categories/youth/ |
| Jamaica Plain/Brighton & Roslindale WIC | https://www.wicprograms.org/state/massachusetts |
| Violence Recovery Program/JPNTT | https://www.brighamandwomens.org/about-bwh/community-health-equity/violence-recovery-program |
| One Family | https://www.onefamilyinc.org/ |
| Community Dispute Settlement Center | www.cdsc.org |
| Year Up | https://www.yearup.org/ |
| Boston Public Library | https://www.bpl.org/ |
| Boston Area Healthy Families | https://childrenstrustma.org/our-programs/healthy-families |
| Youth Options Unlimited (YOU) Boston | http://www.youboston.org/ |
| Passageway | https://www.brighamandwomens.org/about-bwh/community-health-equity/passageway-domestic-abuse-intervention-and-prevention |
| Department of Transitional Assistance | http://www.mass.gov/eohhs/gov/departments/dta/ |
| Planned Parenthood | https://www.plannedparenthood.org/ |

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| Endicott College Boston | http://www.endicott.edu |
| Young Parents Support Program â€“ Cambridge Family & Childrenâ€™s Services | https://www.helpfamilies.org/young-parents-support-program |
| Mothers for Justice and Equality | http://mothersforjusticeandequality.org/ |
| Economic Mobility Pathways â€“ Young Parent Success Program | https://www.empathways.org/direct-services/young-parent-success-program |
| Vital Village Network | http://www.vitalvillage.org |
| Southern Jamaica Plain Health Center | https://www.brighamandwomens.org/medicine/general-internal-medicine-and-primary-care/southern-jamaica-plain-health-center/overview |
| Brookside Community Health Center | https://www.brighamandwomens.org/medicine/general-internal-medicine-and-primary-care/brookside-community-health-center/overview |
| Healthy Baby Essentials | https://enoshomemedical.com/healthcare-professional-services/healthy-baby-essentials/ |
| Jewish Family & Childrenâ€™s Services | https://www.jfcsboston.org/ |
| Health Care Without Walls â€“ Bridges to Moms | https://www.healthcarewithoutwalls.org/our-work/bridges |
| Bridge Over Troubled Waters | https://www.bridgeotw.org/ |
| Cooking Matters | https://ma.cookingmatters.org/ |
| Boston Basics | https://boston.thebasics.org/en/ |

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| **Student Success Jobs Program (SSJP)** | |
|---|---|
| **Program Type** | Total Population or Community-Wide Interventions |
| **Program is part of a grant or funding provided to an outside organization** | No |
| **Program Description** | SSJP is an intensive year-round employment and mentoring program for students of Boston public high schools. With the goal of addressing the under-representation of young people of color in health and science careers, SSJP provides 10th through 12th grade students the opportunity to build skills and a career pathway in the health and science field. Brigham and Women's Hospital (BWH) employees provide intensive mentoring to students in a dynamic and professional hospital environment. Tutoring support is also provided to ensure the academic success of students in their science and mathematics subjects. Individualized assistance enables students to identify their options for higher education and prepare college and financial aid applications. Since inception in 2001, SSJP has served 810 students (100 in FY19). |
| **Program Hashtags** | Mentorship/Career Training/Internship, Physician/Provider Diversity, |
| **Program Contact Information** | Pamela Audeh, Program Director, Center for Community Health and Health Equity, Brigham and Women's Hospital, 41 Avenue Louis Pasteur, Boston, MA 02115 |

**Program Goals:**

| Goal Description | Goal Status | Goal Type | Time Frame |
|---|---|---|---|
| To address the need for proficient and traditionally underrepresented populations in the health, science, and medical careers. | In FY19, 100% of alumni entered college after SSJP or have graduated college, and 63% of those students majored in a health or science field. Sixty percent reported that they were first in their family to enroll in college. | Outcome Goal | Year 3 of 3 |
| To enhance high school students' interest in health careers through mentorship by health care professionals. | In FY19, SSJP recruited 84 health professionals from 59 BWH departments across the hospital to serve as mentors to SSJP. | Process Goal | Year 3 of 3 |
| To support academic progress and post-secondary education of participants. | SSJP maintained 100% college matriculation in FY19. Graduates were accepted into many top universities including: Northeastern University, Tufts University, and Boston University. 100% of program participants cite being exposed to a professional environment as helpful to their getting accepted | Outcome Goal | Year 3 of 3 |

| | | | |
|---|---|---|---|
| | into college. | | |
| To foster networking opportunities for emerging and underrepresented health care professionals with peers and the hospital community. | In FY19, SSJP provided seminars and a day-long retreat to increase communication, team building as well as foster friendships among student participants. | Process Goal | Year 3 of 3 |

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|---|---|
| **EOHHS Focus Issues** | N/A, |
| **DoN Health Priorities** | Education, Social Environment, |
| **Health Issues** | Social Determinants of Health-Education/Learning, Social Determinants of Health-Income and Poverty, Social Determinants of Health-Language/Literacy, |
| **Target Populations** | • **Regions Served:** Boston,<br>• **Environments Served:** All,<br>• **Gender:** All,<br>• **Age Group:** Adult-Young, Child-Teen,<br>• **Race/Ethnicity:** All,<br>• **Language:** All,<br>• **Additional Target Population Status:** Not Specified |

**Partners:**

| Partner Name and Description | Partner Website |
|---|---|
| Boston Latin Academy | http://latinacademy.org/ |
| John D. O'Bryant High School | http://www.obryant.us/ |
| Madison Park High School | http://www.madisonparkhs.org/ |
| New Mission High School | http://www.bostonpublicschools.org/node/497 |
| Community Academy of Science and Health | http://www.bostonpublicschools.org/node/416 |
| Boston Private Industry Council | http://www.bostonpic.org/ |
| Edward M. Kennedy Academy for Health Careers | http://www.kennedyacademy.org/ |
| Urban Science Academy | http://www.urbansci.com/ |
| Fenway High School | http://fenwayhs.org |

## Student Success Jobs Program Summer Internship for College Students (SSJP College)

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|---|---|
| **Program Type** | Total Population or Community-Wide Interventions |
| **Program is part of a grant or funding provided to an outside organization** | No |
| **Program Description** | The Student Success Jobs Program Summer Internship for College Students is an intensive summer employment opportunity for students that have successfully graduated from the Student Success Jobs Program for high school students. SSJP College Summer Internship Program was created to support SSJP graduates, currently in college, majoring in a health-related field. Summer internship opportunities are paid positions in a Brigham and Women's Hospital department and are available to students for ten weeks, 35 hours per week, from June through August. SSJP creates pathways into science, health, or medicine careers for those who have traditionally been underrepresented in the field with 96 percent of students self-identified as people of color. In FY19, 33 students were served. Since inception in 2006, 209 individual students have been served. |
| **Program Hashtags** | Mentorship/Career Training/Internship, Physician/Provider Diversity, |
| **Program Contact Information** | Pamela Audeh, Program Director, Center for Community Health and Health Equity, Brigham and Women's Hospital, 41 Avenue Louis Pasteur, Boston, MA 02115 |

**Program Goals:**

| Goal Description | Goal Status | Goal Type | Time Frame |
|---|---|---|---|

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|---|---|---|---|
| To address the pressing need for under-represented professionals in health, science and medical careers. | In FY19, 33 college students majoring in health, science or medicine were recruited into the SSJP College program and matched students to departments that were closely aligned to their career goals. | Outcome Goal | Year 3 of 3 |
| To strengthen and sustain interest among college students in health careers through work-based mentoring by health care professionals. | In FY19, SSJP recruited 25 BWH health professionals as preceptors who provided internship experiences to students. | Process Goal | Year 3 of 3 |
| To foster networking opportunities for emerging under-represented health care professionals with peers and the hospital community. | In FY19, SSJP provided 33 SSJP college students with paid internships for ten weeks in a BWH department. | Outcome Goal | Year 3 of 3 |

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| **EOHHS Focus Issues** | N/A, |
| **DoN Health Priorities** | Education, Employment, Social Environment, |
| **Health Issues** | Social Determinants of Health-Education/Learning, Social Determinants of Health-Income and Poverty, Social Determinants of Health-Language/Literacy, |
| **Target Populations** | • **Regions Served:** Boston,<br>• **Environments Served:** All,<br>• **Gender:** All,<br>• **Age Group:** Adult-Young,<br>• **Race/Ethnicity:** All,<br>• **Language:** All,<br>• **Additional Target Population Status:** Not Specified |

**Partners:**

| Partner Name and Description | Partner Website |
|---|---|
| Not Specified | Not Specified |

## Summer Science Academy

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|---|---|
| **Program Type** | Total Population or Community-Wide Interventions |
| **Program is part of a grant or funding provided to an outside organization** | No |
| **Program Description** | Summer Science Academy is targeted to rising 9th grade students attending BWH partnering middle schools and organizations in the Mission Hill neighborhood of Roxbury. The goals of the Summer Science Academy are to: 1) engage rising ninth graders from Mission Hill schools and organizations in health and science topics through an interdisciplinary curriculum, scientific literature review, and an introduction to scientific writing; and 2) expose rising ninth grade students to professions in the health and science field. Since inception in 2009, Summer Science Academy has served 185 students. In FY19, Summer Science Academy served 22 students. |
| **Program Hashtags** | Community Education, Mentorship/Career Training/Internship, |
| **Program Contact Information** | Pamela Audeh, Center for Community Health and Health Equity, Brigham and Women's Hospital, 41 Avenue Louis Pasteur, Boston, MA 02115 |

**Program Goals:**

| Goal Description | Goal Status | Goal Type | Time Frame |
|---|---|---|---|
| Engage rising ninth graders from Mission Hill schools and organizations in health and science topics through an interdisciplinary curriculum, scientific literature review, and an introduction to scientific writing. Expose rising ninth grade students to professions in the health and science field. | In FY19, 22 students participated in the six-week program; since inception in 2009, Summer Science Academy has served 185 students. | Process Goal | Year 3 of 3 |

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| To address the need for traditionally under-represented populations in health, science and medical careers. | In FY19, 100% of the participants were youth of color attending schools in Roxbury with over 85% of the school population receiving free and reduced-price lunch (a key indicator of low-income status). | Process Goal | Year 3 of 3 |
| To enhance students' interest in health, science and medical careers through teaching and career exposure by health care professionals. | At the end of the six-week program, 82% of the students reported experiencing positive change in the ability to be part of a team, while 73% reported a positive change in critical thinking, and 75% reported a positive change in academic perseverance. | Outcome Goal | Year 3 of 3 |
| To advance health, science and medical learning for rising ninth grade students in participating Boston Public Schools. | Participants learned about public health topics and did hands on science experiments weekly, while also learning about health careers. All of their learning was recorded and documented in audio podcasts chronicling what they learned and researched. | Process Goal | Year 3 of 3 |

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| **EOHHS Focus Issues** | N/A, |
| **DoN Health Priorities** | Education, Employment, |
| **Health Issues** | Social Determinants of Health-Education/Learning, Social Determinants of Health-Language/Literacy, |
| **Target Populations** | • **Regions Served:** Boston, Boston-Mission Hill, Boston-Roxbury,<br>• **Environments Served:** All,<br>• **Gender:** All,<br>• **Age Group:** Child-Teen,<br>• **Race/Ethnicity:** All,<br>• **Language:** All,<br>• **Additional Target Population Status:** Not Specified |

**Partners:**

| Partner Name and Description | Partner Website |
|---|---|
| Becoming a Man | https://www.youth-guidance.org/bam-boston/ |
| Roxbury Tenants of Harvard | www.roxburytenants.org |
| Boston Teachers Union School | http://www.bostonpublicschools.org/school/boston-teachers-union-school |
| Maurice J. Tobin K-8 School | http://www.bostonpublicschools.org/Page/927 |
| Apprentice Learning | http://apprenticelearning.org/ |
| Lila G. Frederick Middle School | https://www.bostonpublicschools.org/frederick |

## The Passageway Domestic Violence Program

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| **Program Type** | Community-Clinical Linkages |
| **Program is part of a grant or funding provided to an outside organization** | No |
| **Program Description** | Passageway provides free, voluntary, and confidential services to patients, employees and community members who are experiencing domestic violence (DV). This intervention is based on a multidisciplinary and tailored response model that includes domestic violence advocates, nurses, physicians, social workers, mental health providers, security, and other health care providers. The team provides tailored interventions based on the needs of the individual. Passageway advocates come from diverse backgrounds reflecting the populations served. Advocates offer services in English and Spanish, and use hospital interpreters for all other languages. Advocates are on-site at the BWH campus, Brigham and Women's Faulkner Hospital, Southern Jamaica Plain Health Center, Brookside Community Health Center, Whittier Street Health Center. In FY19, Passageway provided services to 837 clients and since inception in 1997, 18,329 people have been served. |
| **Program Hashtags** | Health Screening, Prevention, Support Group, |
| **Program Contact Information** | Mardi Chadwick, J.D. Director Violence Intervention and Prevention Programs, 41 Avenue Louis Pasteur, Boston, MA 02115 |

**Program Goals:**

| Goal Description | Goal Status | Goal Type | Time Frame |
|---|---|---|---|
| Provide free, voluntary, and confidential services to patients, employees and community members who are experiencing domestic violence (DV). | In FY19, the Passageway Program provided services to 837 individuals; since inception in 1997, 18,329 people have been served. | Process Goal | Year 3 of 3 |
| Continue to increase safety, health and well-being of patients, employees and community members by providing comprehensive services to those experiencing domestic violence. | In FY19, the Passageway Program provided 1,087 counseling sessions and contacts to members or on behalf of the 837 patients/employees/community members experiencing domestic violence. | Process Goal | Year 3 of 3 |
| Increase access to services for patients and employees by increasing education and consultation services to health care providers, staff and community members. | In FY19, the Passageway Program provided 24 education/training sessions to 188 health care providers and community members on the impact of DV and health. | Process Goal | Year 3 of 3 |
| Increase access to services for patients and employees by increasing education and consultation services to health care providers regarding domestic violence cases. | In FY19, the Passageway Program provided 211 individual consultations with providers. | Outcome Goal | Year 3 of 3 |

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| **EOHHS Focus Issues** | N/A, |
| **DoN Health Priorities** | Social Environment, Violence, |
| **Health Issues** | Social Determinants of Health-Access to Health Care, Social Determinants of Health-Domestic Violence, Social Determinants of Health-Racism and Discrimination, Social Determinants of Health-Violence and Trauma, |
| **Target Populations** | • **Regions Served:** Boston,<br>• **Environments Served:** All,<br>• **Gender:** All,<br>• **Age Group:** All Adults,<br>• **Race/Ethnicity:** All,<br>• **Language:** All,<br>• **Additional Target Population Status:** Not Specified |

**Partners:**

| Partner Name and Description | Partner Website |
|---|---|
| Jane Doe, Inc. | http://www.janedoe.org/ |
| Conference of Boston Teaching Hospitals | http://www.cobth.org/ |
| WilmerHale Legal Services | http://www.law.harvard.edu/academics/ |
| Whittier Street Health Center | http://www.wshc.org |
| Boston Public Health Commission | http://www.bphc.org |
| HarborCOV | http://www.harborcov.org/ |
| Center for Prevention and Recovery, Beth Israel Lahey Health | https://www.bidmc.org/centers-and-departments/social-work/center-for-violence-prevention-and-recovery |
| Mothers for Justice and Equality | https://mothersforjusticeandequality.org/ |
| MissionSAFE | https://missionsafe.org |
| St. Stephenâ€™s Youth Programs | http://www.ssypboston.org/ |

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| **Program Type** | Infrastructure to Support CB Collaboration |
| **Program is part of a grant or funding provided to an outside organization** | Yes |
| **Program Description** | The Boston CHNA-CHIP Collaborative is an initiative among a number of stakeholders - community organizations, health centers, hospitals and the Boston Public Health Commission - formed to undertake the first city-wide Community Health Needs Assessment (CHNA) and Community Health Improvement Plan (CHIP) for the City of Boston. This Collaborative aims to achieve the benefits of broad partnership around a Boston-based CHNA and CHIP, including deeper engagement of key community and organizational stakeholders; enhanced alignment of defined priorities and strategies; maximal allocation of resources; coordination of implementation strategies for collective impact and a healthier Boston. |
| **Program Hashtags** | Community Health Center Partnership, Prevention, Research, |
| **Program Contact Information** | Michelle Keenan, Senior Director, Health Equity and Social Innovations, Brigham and Womenâ €™s Hospital, Center for Community Health and Health Equity, 4 |

**Program Goals:**

| Goal Description | Goal Status | Goal Type | Time Frame |
|---|---|---|---|
| Participate in a Boston city-wide CHNA to identify the top health-related issues impacting Boston residents. | CHNA completed identifying housing, financial stability and mobility, behavioral health, and accessing services as top priorities. | Outcome Goal | Year 1 of 3 |
| Participate in a Boston city-wide CHIP process to develop strategies for addressing the top health-related issues identified in the CHNA. | CHIP is in development | Outcome Goal | Year 1 of 3 |

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|---|---|
| **EOHHS Focus Issues** | Housing Stability/Homelessness, Mental Illness and Mental Health, Substance Use Disorders, |
| **DoN Health Priorities** | Education, Employment, Housing, |
| **Health Issues** | Health Behaviors/Mental Health-Bereavement, Health Behaviors/Mental Health-Depression, Health Behaviors/Mental Health-Immunization, Health Behaviors/Mental Health-Mental Health, Health Behaviors/Mental Health-Physical Activity, Health Behaviors/Mental Health-Responsible Sexual Behavior, Health Behaviors/Mental Health-Stress Management, Social Determinants of Health-Access to Health Care, Social Determinants of Health-Access to Healthy Food, Social Determinants of Health-Access to Transportation, Social Determinants of Health-Affordable Housing, Social Determinants of Health-Domestic Violence, Social Determinants of Health-Education/Learning, Social Determinants of Health-Environmental Quality, Social Determinants of Health-Homelessness, Social Determinants of Health-Income and Poverty, Social Determinants of Health-Language/Literacy, Social Determinants of Health-Nutrition, Social Determinants of Health-Public Safety, Social Determinants of Health-Racism and Discrimination, Social Determinants of Health-Uninsured/Underinsured, Social Determinants of Health-Violence and Trauma, Substance Addiction-Alcohol Use, Substance Addiction-Driving Under the Influence, Substance Addiction-Opioid Use, Substance Addiction-Smoking/Tobacco Use, Substance Addiction-Substance Use, |
| **Target Populations** | • **Regions Served:** Boston,<br>• **Environments Served:** Urban,<br>• **Gender:** All,<br>• **Age Group:** All,<br>• **Race/Ethnicity:** All,<br>• **Language:** All,<br>• **Additional Target Population Status:** Domestic Violence History, LGBT Status, Refugee/Immigrant Status, |

**Partners:**

| Partner Name and Description | Partner Website |
|---|---|
| Boston CHNA-CHIP Collaborative | www.bostonchna.org |

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## Violence Recovery Program

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|---|---|
| **Program Type** | Community-Clinical Linkages |

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| **Program is part of a grant or funding provided to an outside organization** | No |
| **Program Description** | The Violence Recovery Program works to reduce the disproportionate burden of violence in our communities and improve health outcomes through direct interventions, education, prevention, community building and trauma recovery. Our prevention efforts focus on increasing awareness and education on the adverse health effects of all intentional violence on both an individual and community level. The Violence Recovery Program (VRP) works collaboratively with the Burn, Trauma and Surgical Critical Care Division (BTSCC) to provide direct intervention to any patient admitted to BWH as a result of intentional violence. The Violence Recovery advocates meet with patients within 24 hours of admission, provide safety assessments, and help develop an individualized plan for ongoing advocacy and support after discharge. The VRP also provides supportive services to the patient's family and significant others as appropriate. The VRP provides ongoing support, case management and community referrals as needed for patients after discharge. In FY19, the program worked with 137 people. Since program inception in 2011, we have worked with 980 people. In 2017, the Violence Recovery Program received funding from the Boston Public Health Commission to participate in the city-wide trauma response teams. In FY19, we continued to partner with our licensed community health centers, Brookside and Southern Jamaica Plain Health Centers, community-based organization Tree of Life/Arbor del Vida, and Martha Eliot Health Center to provide immediate crisis response to individuals and the community in Jamaica Plain and parts of Mission Hill who experience violent trauma. |
| **Program Hashtags** | Community Education, Prevention, Support Group, |
| **Program Contact Information** | Mardi Chadwick, J.D. Director Violence Intervention and Prevention Programs, 41 Avenue Louis Pasteur, Boston, MA 02115 |

**Program Goals:**

| Goal Description | Goal Status | Goal Type | Time Frame |
|---|---|---|---|
| Address the burden of violence in Boston by improving the outcomes of individuals exposed to violence through a focus on safety planning, risk reduction, asset promotion, trauma recovery and prevention. | In FY19, the Violence Recovery Program provided services to 137 individuals; since its 2011 inception, 980 people have been served. | Process Goal | Year 3 of 3 |
| Increase awareness and understanding of violence as a social determinant of health, and the impact exposure to multiple forms of violence have on individuals and our communities. | In FY19, the Violence Recovery Program team members attended 212 different meetings and events to raise awareness and work collaboratively on issues of violence exposure. | Process Goal | Year 3 of 3 |

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|---|---|
| **EOHHS Focus Issues** | N/A, |
| **DoN Health Priorities** | Education, Social Environment, Violence, |
| **Health Issues** | Social Determinants of Health-Access to Health Care, Social Determinants of Health-Racism and Discrimination, Social Determinants of Health-Violence and Trauma, |
| **Target Populations** | • **Regions Served:** Boston,<br>• **Environments Served:** All,<br>• **Gender:** All,<br>• **Age Group:** Adult-Young, All Adults, Child-Preteen,<br>• **Race/Ethnicity:** All,<br>• **Language:** All,<br>• **Additional Target Population Status:** Not Specified |

**Partners:**

| Partner Name and Description | Partner Website |
|---|---|
| Boston Center for Youth and Families | http://www.cityofboston.gov/BCYF/ |
| Louis D. Brown Peace Institute | http://www.ldbpeaceinstitute.org/ |
| Boston Medical Center- Violence Intervention and Advocacy Program | http://www.bmc.org/violence-intervention-advocacy.htm |

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| Youth Options Unlimited | http://youboston.org |
| Youth Connect | http://www.youboston.org/partner-profiles/boys-and-girls-clubs-of-boston/ |
| Roxbury Presbyterian Church Social Impact Center | https://rpcsocialimpactctr.org/ |
| Martha Eliot Health Center | http://www.childrenshospital.org/about-us/locations/boston-childrens-at-martha-eliot-health-center# |
| JP Tree of Life/Arbor del Vida | Not Specified |
| MassHousing | www.masshousing.com |
| Boston Police Department | www.bpdnews.com |
| Boston Public Health Commission | www.bphc.org |
| Operation Exit Boston | www.owd.boston.gov/tag/operation-exit |
| Score for More | Not Specified |
| Urban Edge | www.urbanedge.org |
| The PIM Project | www.thepimproject.org |
| Boston Housing Authority | www.bostonhousing.org |
| Boston Trauma Team- JRI | https://jri.org/services/behavioral-health-and-trauma/boston-trauma |

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## Brigham and Women's Hospital Certified Application Counselors

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|---|---|
| **Program Type** | Access/Coverage Supports |
| **Program is part of a grant or funding provided to an outside organization** | No |
| **Program Description** | Brigham and Women's Hospital Certified Application Counselors (CACs) provide information about the full range of insurance programs offered by EOHHS and the Health Connector. Our CACs help individuals complete an application or renewal; work with the individual to provide required documentation; submit applications and renewals for the Insurance Programs; interact with EOHHS and the Health Connector on the status of such applications and renewals; and help facilitate enrollment of applicants or beneficiaries in Insurance Programs. In FY19, BWH CACs contributed to the estimated 68 patient financial counselors that served patients who needed assistance with their coverage. |
| **Program Hashtags** | Prevention, |
| **Program Contact Information** | Kim Simonian, Director for Public Payer Patient Access, Community Health, Partners Healthcare |

**Program Goals:**

| Goal Description | Goal Status | Goal Type | Time Frame |
|---|---|---|---|
| Provide information about the full range of insurance programs offered by EOHHS and the Health Connector. | In FY19, BWH CACs contributed to the estimated 68 patient financial counselors that served patients who needed assistance with their coverage. | Process Goal | Year 1 of 3 |

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|---|---|
| **EOHHS Focus Issues** | N/A, |
| **DoN Health Priorities** | N/A, |
| **Health Issues** | Social Determinants of Health-Access to Health Care, |
| **Target Populations** | • **Regions Served:** Boston,<br>• **Environments Served:** All,<br>• **Gender:** All,<br>• **Age Group:** All,<br>• **Race/Ethnicity:** All,<br>• **Language:** All,<br>• **Additional Target Population Status:** Not Specified |

**Partners:**

| Partner Name and Description | Partner Website |
|---|---|
| Health Care For All | https://www.hcfama.org/ |
| Mass Health | http://www.mass.gov/eohhs/gov/departments/masshealth/ |
| Massachusetts Health Connector | https://betterhealthconnector.com/ |
| Massachusetts Hospital Association | https://www.mhalink.org/ |
| Massachusetts League of Community Health Centers | http://www.massleague.org/ |

## Community Health Center Affiliations

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|---|---|
| **Program Type** | Access/Coverage Supports |
| **Program is part of a grant or funding provided to an outside organization** | Yes |
| **Program Description** | Partners has a long commitment to community health centers. MGH's licensed community health center in Charlestown was founded in 1968, and Brookside Community Health Center became part of BWH in 1974. Today, there are five licensed health centers operating within the overall Partners system: three of which operate through the license of MGH in Charlestown, Chelsea, and Revere and two of which operate under the license of BWH in Jamaica Plain -- Brookside CHC and Southern Jamaica Plain CHC. In addition, Partners is affiliated with 15 community health centers in Dorchester, East Boston, Jamaica Plain, Lynn, Mattapan, North End, Peabody, Roxbury, Salem, South Boston, and the South End. Since 1996, Partners and its hospitals have provided more than $40 million in support to these affiliated CHCs to rebuild, relocate, or modernize aging facilities.<br><br>MGH, BWH, and Partners have made a concerted effort to improve access to care for community health center patients, helping health centers move from cramped, outdated buildings to modern facilities with updated computer information systems and medical technology. Over time, our relationships with each of these health centers have evolved uniquely for each health center to provide the most responsive support possible. |
| **Program Hashtags** | Community Health Center Partnership, |
| **Program Contact Information** | Kristen Barnicle, Executive Director, Partners Community Health, 857-282-1421 |

**Program Goals:**

| Goal Description | Goal Status | Goal Type | Time Frame |
|---|---|---|---|
| Provide access to community-based health care. | Partners is affiliated with 15 community health centers in Dorchester, East Boston, Lynn, Mattapan, North End, Peabody, Roxbury, Salem, South Boston, and the South End. | Process Goal | Year 3 of 3 |
| Strengthen community health centers in Partners communities. | Since 1996, Partners and its hospitals have provided more than $40 million in support to these affiliated CHCs to rebuild, relocate, or modernize aging facilities. | Process Goal | Year 3 of 3 |
| Improve access to care for community health center patients. | Gynecologists and nurse midwives from BWH provide clinical care at affiliated community health centers in Dorchester, Mattapan, Roxbury, and the South End. | Process Goal | Year 3 of 3 |
| Improve access to care for community health center patients. | The MGH AVON program provides navigators to help patients from Chelsea and Mattapan get breast cancer screening, follow up and treatment. | Process Goal | Year 3 of 3 |
| Improve access to care for community health center patients. | North Shore Medical Center cardiologists and urologists provide treatment for patients in Lynn. | Process Goal | Year 3 of 3 |
| Expand the state's supply of primary care providers at community health centers. | The Mass. League's CHC Provider Loan Repayment Program- Through 2018, more than 300 primary care providers have committed to work in a CHC for up to two years in exchange for loan repayment. | Outcome Goal | Year 3 of 3 |

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|---|---|---|---|
| Support the state's community health centers in their continued efforts to reduce barriers to access, promote health equity and organize care for patients in their communities. | Grants awarded through the Partnership for Community Health have provided support to community health centers to develop and launch measurable programs that enhance health outcomes, services, efficiencies and quality of care. | Outcome Goal | Year 3 of 3 |
| Provide hunger assistance grants to licensed and affiliated community health centers. | Provided $500 grants to 17 licensed and affiliated community health centers to support new or existing hunger assistance activities. | Outcome Goal | Year 3 of 3 |
| Provide grants to support licensed and affiliated health centers with existing food pantries. | Provided $5000 grants to support 6 of our licensed and affiliated community health centers with onsite food pantries. | Outcome Goal | Year 3 of 3 |
| Provide access to community-based health care. | For more than 84,500 children and adult patients of BWH and MGH licensed health centers in FY19. | Outcome Goal | Year 3 of 3 |

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| **EOHHS Focus Issues** | Chronic Disease with focus on Cancer, Heart Disease, and Diabetes, |
| **DoN Health Priorities** | N/A, |
| **Health Issues** | Cancer-Breast, Chronic Disease-Cardiac Disease, Chronic Disease-Diabetes, Health Behaviors/Mental Health-Mental Health, Maternal/Child Health-Reproductive and Maternal Health, Social Determinants of Health-Access to Health Care, Social Determinants of Health-Nutrition, |
| **Target Populations** | • **Regions Served:** Boston, Chelsea, Lynn, Peabody, Revere, Salem,<br>• **Environments Served:** All,<br>• **Gender:** All,<br>• **Age Group:** All,<br>• **Race/Ethnicity:** All,<br>• **Language:** All,<br>• **Additional Target Population Status:** Not Specified |

**Partners:**

| Partner Name and Description | Partner Website |
|---|---|
| Boston Health Care for the Homeless Program | http://www.bhchp.org/ |
| Brookside Community Health Center (BWH) | http://www.brighamandwomens.org/Departments_and_Services/medicine/services/primarycare/Offices/Brookside.aspx |
| Codman Square Health Center | http://www.codman.org/ |
| Dorchester House Multi-Service Center | http://www.dorchesterhouse.org/ |
| East Boston Neighborhood Health Center | http://www.ebnhc.org/ |
| GeigerGibson Community Health Center | http://www.hhsi.us/metro-boston/geiger-gibson-community-health-center/ |
| Lynn Community Health Center | http://www.lchcnet.org/ |
| Mattapan Community Health Center | http://www.mattapanchc.org/ |

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| MGH Revere HealthCare Center | http://www.massgeneral.org/revere/ |
| MGH Charlestown Health Center | http://www2.massgeneral.org/ctweb/index.htm |
| MGH Chelsea Health Center | MGH Chelsea Health Center |
| Neponset Health Center | http://www.hhsi.us/metro-boston/neponset-health-center/ |
| North End Waterfront Health | http://www.massgeneral.org/northend/ |
| North Shore Community Health, Inc. (NSCHI) includes Salem Family HC & Peabody Family HC | http://www.nschi.org |
| South Boston Community Health Center | http://www.sbchc.org/ |
| South End Community Health Center (SECHC) | http://www.sechc.org/en/ |
| Southern Jamaica Plain Health Center (BWH) | http://www.brighamandwomens.org/Departments_and_Services/medicine/services/primarycare/sjphc/default.aspx |
| Upham's Corner Health Center | www.uphamscornerhealthctr.com/ |
| Whittier Street Health Center | http://www.whittierstreet.org/ |

## Interpreter Services

| | |
|---|---|
| **Program Type** | Access/Coverage Supports |
| **Program is part of a grant or funding provided to an outside organization** | No |
| **Program Description** | The Interpreter Services program at BWH assures access to quality health care for non-English speaking and deaf and hard of hearing patients and families by providing language interpretation and translation of key health care documents. |
| **Program Hashtags** | Not Specified |
| **Program Contact Information** | Yilu Ma, Director, Interpreter Services Department, Brigham and Womenâ€™s Hospital, 75 Francis Street, Boston, MA 02115 |

**Program Goals:**

| Goal Description | Goal Status | Goal Type | Time Frame |
|---|---|---|---|
| To assure access to quality health | | | |

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|---|---|---|---|
| care for non-English speaking and deaf and hard of hearing patients and families by providing language interpretation and translation of key health care documents. | In FY19, about 338,887 unduplicated patients were served. Interpreter Services had a total of 1,201,580 outpatient encounters and 43,740 inpatient encounters. | Outcome Goal | Year 1 of 3 |

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|---|---|
| **EOHHS Focus Issues** | N/A, |
| **DoN Health Priorities** | Social Environment, |
| **Health Issues** | Other-Hearing, Social Determinants of Health-Access to Health Care, Social Determinants of Health-Language/Literacy, |
| **Target Populations** | • **Regions Served:** All Massachusetts,<br>• **Environments Served:** All,<br>• **Gender:** All,<br>• **Age Group:** All,<br>• **Race/Ethnicity:** All,<br>• **Language:** All,<br>• **Additional Target Population Status:** Disability Status, Refugee/Immigrant Status, |

**Partners:**

| Partner Name and Description | Partner Website |
|---|---|
| Not Specified | Not Specified |

## The Mass. League's CHC Provider Loan Repayment Program

| | |
|---|---|
| **Program Type** | Access/Coverage Supports |
| **Program is part of a grant or funding provided to an outside organization** | Yes |
| **Program Description** | Partners collaborates with the Massachusetts League of Community Health Centers (Mass. League) and other organizations to ensure patients have access to primary care close to home. Toward that end, since 2007, Partners has provided annual funding to support the administration of state-wide educational loan repayment programs for primary care providers and other clinicians and grant programs to retain existing clinicians. The Mass. League has worked with a variety of funders to support these initiatives over the past 13 years, including Bank of America, Mass. Dept. of Public Health, Mass. Dept. of Mental Health, and MassHealth. Several hundred clinicians, including primary care physicians, nurse practitioners, dentists, and social workers have benefited from these programs. |
| **Program Hashtags** | Community Health Center Partnership, Health Professional/Staff Training, |
| **Program Contact Information** | Kristen Barnicle, Executive Director, Partners Community Health, 857-282-1421 |

**Program Goals:**

| Goal Description | Goal Status | Goal Type | Time Frame |
|---|---|---|---|
| Expand the state's supply of primary care providers at community health centers. | The Mass. League's CHC Provider Loan Repayment Program: Since 2007, more than 300 providers have committed to work in a community health center for up to three years in exchange for loan repayment. | Outcome Goal | Year 3 of 3 |
| Encourage retention of primary care providers at community health centers. | Since 2009, more than 80 special project grants have been awarded to providers at Massachusetts community health centers. | Process Goal | Year 3 of 3 |

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|---|---|
| **EOHHS Focus Issues** | Chronic Disease with focus on Cancer, Heart Disease, and Diabetes, Mental Illness and Mental Health, |
| **DoN Health Priorities** | N/A, |
| **Health Issues** | Chronic Disease-Diabetes, Health Behaviors/Mental Health-Mental Health, Social Determinants of Health-Access to Health Care, |
| **Target Populations** | • **Regions Served:** All Massachusetts, |

- **Environments Served:** All,
- **Gender:** All,
- **Age Group:** All,
- **Race/Ethnicity:** All,
- **Language:** All,
- **Additional Target Population Status:** Not Specified

**Partners:**

| Partner Name and Description | Partner Website |
|---|---|
| Mass League of CHCs | https://www.massleague.org/ |

## Partners in Career and Workforce Development (PCWD) Health Care training and Employment Program

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|---|---|
| **Program Type** | Total Population or Community-Wide Interventions |
| **Program is part of a grant or funding provided to an outside organization** | No |
| **Program Description** | The Partners in Career and Workforce Development (PCWD) program addresses the Boston health care industry's need for a highly skilled diverse workforce, incumbent employees' interests in career advancement, and the Boston community's desire to provide stable careers with growth potential and family-sustaining wages to low-income residents. Launched in 2003, PCWD is jointly operated by Partners HealthCare Human Resources and Community Health. Through collaboration with Project Hope, a multi-service community- based agency located in Roxbury, MA, PCWD provides low to middle-skilled community residents with training, internships, career counseling/case management and job placement services (with average starting salary of $17.02/hr during 7/1/18-6/30/19, generous benefits, and opportunities for academic and career growth within Partners HealthCare affiliates. The rigorous, 8- week program focuses on preparing to work in a health care environment, medical terminology, HIPAA, and job readiness skills. Upon completion of classroom instruction and internships, PCWD graduates are placed in a variety of positions, including but not limited to patient service coordinator, unit coordinator, operations associate and office/staff assistant. In response to hospital need and current employment market, PCWD successfully launched a 7-week pilot CNA/PCA training program (Feb-April 2018), which enrolled, trained and graduated 19 individuals who passed their CNA Certification State Exam and were placed at Spaulding Rehabilitation Network. Following the success of the pilot program, two 5- week PCA training cycles (Jan-March 2019, April-May 2019) were held and graduated 26 additional individuals who were placed at Spaulding Rehabilitation Network. Since inception, 679 participants have graduated from the community programs (634 from the traditional PCWD and 45 from PCA/CNA), 48 between July 2018-June 2019. Please visit www.partners.org/jobtraining for more information. All data provided in this report includes one PCWD cycle and two PCA/CNA cycles between July 2018 and June 2019. |
| **Program Hashtags** | Health Professional/Staff Training, Mentorship/Career Training/Internship, |
| **Program Contact Information** | MJ Ryan, Partners HealthCare Workforce Development Director; Elena Kuyun, PCWD Community Program Manager |

**Program Goals:**

| Goal Description | Goal Status | Goal Type | Time Frame |
|---|---|---|---|
| Provide low-income community residents with training, career coaching/case management, internships and job placement services which offer family-sustaining wages, generous benefits, and opportunities for advancement within Partners HealthCare while meeting managers' needs for highly skilled employees. | Partners in Career and Workforce Development ("PCWD") health care training and employment program served 10 participants in the traditional PCWD and 26 in the PCA/CNA program during the period starting July 2018 and ending June 2019, all of them graduated and placed; 88.32% (560 of 634) of eligible traditional PCWD program graduates have been placed within Partners and its member institutions since the program's inception in 2004. One hundred percent (45 of 45) of eligible PCA(CNA) program graduates have been placed. From July 2018 to June 2019 the average starting salary was $17.02/hr. for the traditional PCWD program and $15.45/hr. for the PCA (CNA) program. The average starting salary at program inception was $14.52/hr. for traditional PCWD and $15.33/hr. for PCA(CNA) program. | Outcome Goal | Year 1 of 3 |
| | Graduates are eligible to participate, after meeting employer- | | |

| | | | |
|---|---|---|---|
| Connect program graduates to Partners HealthCare and affiliate-based Workforce Development programs and resources. | specific criteria, in onsite career development classes and initiatives from<br>educational opportunities to advanced clinical training, career and academic coaching, and leadership development. Onsite classes offered within various Partners member institutions include: English for Speakers of Other Languages (ESOL); Adult Basic Education (ABE); pre-college; computer skills; management & leadership training as well as specific clinical & non-clinical advanced training opportunities. After six months of employment, graduates seeking career advancement opportunities are referred to the Partners HealthCare Career Coach who will work with them one-on-one to set personal and professional goals and guide them as they work towards them. PCWD graduates are also offered resources to advance in their career through Partners HealthCare Advancing Careers Through Education Program, which includes assessment, academic, and college readiness support.<br>During the period from FY10 through FY19, 75 PCWD graduates enrolled in the Partners HealthCare Online College Preparation Program (OCPP) and other online programs, designed to help individuals navigate the online learning environment. Online educational options help to increase access to higher education for working adults. From FY14 to June of FY19,<br>24 PCWD graduates participated in College for America (CfA), and are currently enrolled in online, competency-based, AA degree, BA degree and Certificate programs. | Outcome Goal | Year 1 of 3 |
| Based on the successful completion (100% graduation/placement rate) of our CNA Training Program, run three cycles of PCA/CNA training in FY 2020 instead of traditional PCWD classes. | Offer the PCA/CNA training program in January, April and August of 2020 and place the graduates at Spaulding Rehabilitation Network or other Partners affiliates based on labor market and hospital needs. | Process Goal | Year 1 of 3 |

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| **EOHHS Focus Issues** | N/A, |
| **DoN Health Priorities** | Education, Employment, |
| **Health Issues** | Social Determinants of Health-Education/Learning, Social Determinants of Health-Income and Poverty, |
| **Target Populations** | • **Regions Served:** All Massachusetts,<br>• **Environments Served:** All,<br>• **Gender:** All,<br>• **Age Group:** Adults,<br>• **Race/Ethnicity:** All,<br>• **Language:** All,<br>• **Additional Target Population Status:** Not Specified |

**Partners:**

| Partner Name and Description | Partner Website |
|---|---|
| Project Hope | www.prohope.org |
| Jewish Vocational Service | www.jvs-boston.org |

## Health Explorers at Camp Harbor View

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|---|---|
| **Program Type** | Total Population or Community-Wide Interventions |
| **Program is part of a grant or funding provided to an outside organization** | Yes |
| **Program Description** | As part of Partners commitment to building tomorrow's health care workforce, Partners has developed a partnership with Camp Harbor View to engage campers' curiosity about science, introduce them to the educational connections between school and health careers and promote healthy choices and behaviors. Camp Harbor View, located on Long Island in Boston Harbor, provides a learning and camp environment for over 900 Boston children and adolescents. It is funded through the Camp Harbor View Foundation, a nonprofit organization. Each summer, |

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| | Partners organizes two Health Career Education days to introduce campers to the idea of working in the medical field. Over 40 staff members from Partners affiliated hospitals visit the camp and work through fun activities such as teaching campers how to make casts using inflatable gloves, playing a life- sized game of operation and promoting teamwork in an operating room by dressing campers in OR-scrubs and completing an obstacle course. Campers also learn about different professions including speech pathology and physical therapy and the education required to hold those positions. Some Leaders in Training (LITs, ages 14-17) interested in careers in health care also take part in two-week internships at hospitals and health centers affiliated with Partners HealthCare. These internships offer older teenagers a chance to see what a future in health care might look like, and equips them with the knowledge to seek out that path. LITs are also able to take advantage of resume writing workshops put on at the camp by Partners Workforce Development group.<br><br>With a focus on low income children and adolescents, most of whom are African American and Latino, Camp Harborview introduces campers to health care and science as a career path. |
| **Program Hashtags** | Mentorship/Career Training/Internship, |
| **Program Contact Information** | Kristen Barnicle, Executive Director, Community Health, 857-282-1421, |

**Program Goals:**

| Goal Description | Goal Status | Goal Type | Time Frame |
|---|---|---|---|
| Educate campers about careers in healthcare. | In FY19, Partners sponsored two Health Career Education days for campers giving them the opportunity to meet with 40 health care professionals and ask questions about their career path and daily work while participating in fun interactive activities. | Outcome Goal | Year 3 of 3 |
| Continue to engage campers beyond the summer sessions/provide career training. | In FY19, Partners offered two-week internships to six Leaders in Training and Spaulding Hospital and satellite sites to provide insight into what a future career in health care might look like. | Outcome Goal | Year 3 of 3 |
| Provide career training to campers. | In FY19, Partners Workforce Development team hosted resume writing workshops that taught campers how to write a resume and cover letter and held mock interviews. | Outcome Goal | Year 3 of 3 |

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|---|---|
| **EOHHS Focus Issues** | N/A, |
| **DoN Health Priorities** | Education, |
| **Health Issues** | Social Determinants of Health-Education/Learning, Social Determinants of Health-Income and Poverty, |
| **Target Populations** | • **Regions Served:** Boston,<br>• **Environments Served:** Urban,<br>• **Gender:** All,<br>• **Age Group:** Children, Teenagers,<br>• **Race/Ethnicity:** All,<br>• **Language:** English,<br>• **Additional Target Population Status:** Not Specified |

**Partners:**

| Partner Name and Description | Partner Website |
|---|---|
| Camp Harbor View | http://chvf.org/ |
| Boys and Girls Clubs of Boston | http://www.bgcb.org |

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## Mass General Brigham Summer Jobs Program

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| **Program Type** | Total Population or Community-Wide Interventions |
| **Program is part of a grant or funding provided to an outside organization** | No |
| **Program Description** | Brigham and Women's Hospital and Massachusetts General Hospital, founding members of Mass General Brigham, are leaders at providing summer job opportunities for Boston's youth through Mayor Walsh's Summer Jobs Program. In 2019, about 463 Boston Public School students had jobs at BWH, MGH, and Faulkner through this program. The total count for all |

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| | summer jobs across Mass General Brigham hospitals in 2019 was as follows:<br>Brigham and Women's Hospital: 208<br>Brigham and Women's Faulkner Hospital: 10<br>Massachusetts General Hospital: 245<br>Newton Wellesley Hospital: 14<br>North Shore Medical Center: 18 |
| **Program Hashtags** | Mentorship/Career Training/Internship, |
| **Program Contact Information** | Kristen Barnicle, Executive Director, Community Health, 857-282-1421, |

**Program Goals:**

| Goal Description | Goal Status | Goal Type | Time Frame |
|---|---|---|---|
| Provide students with meaningful summer job experiences and mentoring. | In FY19, 495 students were hired for summer positions at Brigham and Women's Hospital, Brigham and Women's Faulkner Hospital, Massachusetts General Hospital, Newton Wellesley Hospital, and North Shore Medical Center. | Outcome Goal | Year 3 of 3 |

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|---|---|
| **EOHHS Focus Issues** | N/A, |
| **DoN Health Priorities** | Education, |
| **Health Issues** | Social Determinants of Health-Education/Learning, Social Determinants of Health-Income and Poverty, |
| **Target Populations** | • **Regions Served:** Boston, Chelsea, Lynn, Newton, Revere,<br>• **Environments Served:** Urban,<br>• **Gender:** All,<br>• **Age Group:** Teenagers,<br>• **Race/Ethnicity:** All,<br>• **Language:** English,<br>• **Additional Target Population Status:** Not Specified |

**Partners:**

| Partner Name and Description | Partner Website |
|---|---|
| Brigham and Womenâ€™s Hospital Summer Jobs Program | http://www.brighamandwomens.org/about_bwh/communityprograms/our-programs/youth-programs/default.aspx?sub=0 |
| Massachusetts General Hospital Summer Jobs Program | http://www.massgeneral.org/cchi/services/treatmentprograms.aspx?id=1493&display=overview |

## Scholarship Program

| | |
|---|---|
| **Program Type** | Total Population or Community-Wide Interventions |
| **Program is part of a grant or funding provided to an outside organization** | Yes |
| **Program Description** | The Scholarship Program was established in 2012 to provide assistance in applying to and attending college, partial scholarships, and academic support services to enhance the educational success of low income high school students participating in the Brigham and Women's Hospital Student Success Jobs Program and the MGH Youth Scholars Program. The aim of the program is also to address the need for proficient and traditionally under-represented populations in health, science and medical careers to enter, persist, and graduate from college. In addition to students receiving renewable, partial four- year scholarships upon matriculation to college, students also receive educational support including academic tutoring in math and science, college preparation for the SAT exam and financial aid, mentoring and career exposure at BWH and MGH, as well as social support and life skills. All students who receive scholarships are referred to as Scholars.<br><br>A longitudinal evaluation conducted annually indicates the following results:, 82% of Scholars graduated from college in five years compared to national average of 55% in six years; Scholars average SAT scores are 7% higher than their BPS peers; Black and Latino Scholars are staying enrolled in college at higher rates than their national peers (91% compared to 67%); 76% of Scholars attend four year colleges compared to 47% of BPS students and 60% across Massachusetts; 92% of Scholars did not need remedial classes while attending college. |

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| **Program Hashtags** | Mentorship/Career Training/Internship, |
| **Program Contact Information** | Pamela Audeh, Center for Community Health and Health Equity, Brigham and Women's Hospital, and Christy Egun, Center for Community Health Improvement |

**Program Goals:**

| Goal Description | Goal Status | Goal Type | Time Frame |
|---|---|---|---|
| To provide high school graduates of the BWH SSJP program and MGH Youth Scholars with four year renewable scholarships. | In FY19, 184 renewable scholarships were provided: 96 at BWH and 88 at MGH. | Outcome Goal | Year 3 of 3 |
| To support high school students as they prepare for college. | During FY19, BWH and MGH offered intense math and science tutoring to all students whose average fell below a B-. SAT prep classes were conducted throughout the school year for sophomores and juniors. The average SAT scores of participating students are 7% higher. The program also provided college application assistance, and financial assistance; college visits were also facilitated. | Outcome Goal | Year 3 of 3 |
| To support high school students as they prepare for college. | Program staff provide coaching to college students to help them with problems students may encounter and help enable them to stay enrolled in college. | Process Goal | Year 3 of 3 |
| To support high school students as they prepare for college | To date, 126 students have finished college: 79 at BWH and 47 at MGH. Of these 54 are employed - 27 at BWH, MGH or a Mass General Brigham affiliate. Nineteen are pursuing graduate education, either medical school or grad school. | Outcome Goal | Year 3 of 3 |
| To provide work experience and career training/internships. | In FY19, BWH and MGH offered high school students paid school year and summer internships. Over 95% of our students rated the paid internship experience as very important for their professional growth. | Outcome Goal | Year 3 of 3 |

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|---|---|
| **EOHHS Focus Issues** | N/A, |
| **DoN Health Priorities** | Education, |
| **Health Issues** | Social Determinants of Health-Education/Learning, Social Determinants of Health-Income and Poverty, |
| **Target Populations** | • **Regions Served:** Boston, Chelsea, Revere,<br>• **Environments Served:** Urban,<br>• **Gender:** All,<br>• **Age Group:** Teenagers,<br>• **Race/Ethnicity:** All,<br>• **Language:** English,<br>• **Additional Target Population Status:** Not Specified |

**Partners:**

| Partner Name and Description | Partner Website |
|---|---|
| Brigham and Womenâ€™s Hospital Student Success Jobs Program | http://www.brighamandwomens.org/about_bwh/communityprograms /ssjp/default.aspx |
| Mass General Hospital Youth Scholars Program | http://www.massgeneral.org/cchi/services/treatmentprograms.aspx?id =1494 |
| Boston Public Schools | http://www.bostonpublicschools.org/ |

## Rize Massachusetts

| | |
|---|---|
| **Program Type** | Total Population or Community-Wide Interventions |
| **Program is part of a grant or funding provided to an outside organization** | Yes |
| **Program Description** | RIZE Massachusetts Foundation (RIZE) was founded in response to the opioid overdose crisis. RIZE is dedicated to expanding access to treatment and other services for opioid use disorder |

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| | (OUD), measuring the effectiveness of our work, and replicating programs achieving the greatest impact. To date, RIZE has distributed over $4.9 million in grants to more than fifty Massachusetts organizations.<br>RIZE's focus areas are: care - comprehensive, compassionate, and sustainable approaches to prevention, harm reduction, treatment, and recovery; knowledge - data, commissioned research, and evaluation to expand the evidence base and inform policy; and human impact efforts to reduce the economic impact on workers, businesses, and communities. We conduct our work mainly in three ways: grantmaking; policy and research; and convenings. |
| **Program Hashtags** | Research, |
| **Program Contact Information** | RIZE Massachusetts Foundation, Inc. 101 Huntington Ave., Suite 1300, MS 0116 MA 02199 |

**Program Goals:**

| Goal Description | Goal Status | Goal Type | Time Frame |
|---|---|---|---|
| Commission research studies to generate new knowledge about: evidence-based strategies to address the epidemic<br>the economic and social imperative to address the crisis; systems, regulatory, and stigma-related barriers; and the needs and opportunities related to the epidemic.<br>use the data gathered from our grant program evaluations to generate new knowledge about the impact of RIZE-funded programs and successful approaches to harm reduction, treatment, and recovery support. | Findings from research we commissioned on the effectiveness of recovery coaches in OUD treatment were presented to the Massachusetts Recovery Coach Commission and referenced in the official commission findings.<br>In addition, the research we commissioned from the Massachusetts Health Policy Forum and the Massachusetts Taxpayers Foundation on the impact of the opioid crisis on our workforce and economy were presented in stakeholders at forums that were attended by approximately 500 attendees combined, including Governor Baker and Attorney General Maura Healy. Both reports were downloaded more than 1,000 times from the RIZE website. | Outcome Goal | Year 3 of 3 |
| Commission research studies to generate new knowledge about: evidence-based strategies to address the epidemic<br>the economic and social imperative to address the crisis; systems, regulatory, and stigma-related barriers; and the needs and opportunities related to the epidemic.<br>use the data gathered from our grant program evaluations to generate new knowledge about the impact of RIZE-funded programs and successful approaches to harm reduction, treatment, and recovery support. | RIZE also commissioned research on stigma in the health care professions, which shows that one in four emergency medicine or family/internal medicine providers feel that treating patients with OUD will attract undesirable patients to their practice. The findings were cited in the Massachusetts legislature's Medication Assisted Treatment Commission report and widely covered by the media. | Outcome Goal | Year 3 of 3 |
| Provide effective and compassionate services and supports to people with OUD; address barriers to care for people with OUD; and support the staff who are providing services to people with OUD by equipping them to do their work effectively, compassionately, and sustainably. | To date, RIZE has distributed over $4.9 million in grants to more than fifty Massachusetts organizations. An example is our Saving Lives, Improving Health: Redesigning Opioid Use Disorder Care - $2.1 million grant program focused on collaborative approaches to expanding access to community-based treatment. After one year, in three out of the four programs funded, 1,466 patients combined started medicated assisted treatment (MAT) and over half of these patients were still engaged in treatment a year later, despite experiencing significant socioeconomic difficulties. | Outcome Goal | Year 1 of 3 |

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|---|---|
| **EOHHS Focus Issues** | Substance Use Disorders, |
| **DoN Health Priorities** | N/A, |
| **Health Issues** | Substance Addiction-Opioid Use, Substance Addiction-Substance Use, |
| **Target Populations** | • **Regions Served:** All Massachusetts,<br>• **Environments Served:** All, |

- **Gender:** All,
- **Age Group:** All,
- **Race/Ethnicity:** All,
- **Language:** All,
- **Additional Target Population Status:** Not Specified

**Partners:**

| Partner Name and Description | Partner Website |
|---|---|
| AIDS Support Group Cape Cod | Not Specified |
| Boston Healthcare for the Homeless Program | Not Specified |
| Boston Public Health Commission | Not Specified |
| Brandeis University | Not Specified |
| Brockton Neighborhood Health Center | Not Specified |
| Cambridge Health Alliance | Not Specified |
| Center for Human Development | Not Specified |
| Charlestown HealthCare Center â€" MGH | Not Specified |
| City of Chelsea | Not Specified |
| City of Everett | Not Specified |
| City of Medford | Not Specified |
| Community Healthlink | Not Specified |
| Fenway Health | Not Specified |
| FrameWorks Institute | Not Specified |
| Geiger Gibson Community Health Center | Not Specified |
| Greater Lawrence Family Health Center | Not Specified |
| Greater Roslindale Medical and Dental Center | Not Specified |
| Harbor Health Services | Not Specified |
| Health Resources in Action | Not Specified |
| HRH413 | Not Specified |
| Institute for Community Health | Not Specified |
| Kraft Center at MGH | Not Specified |
| Life Connection Center | Not Specified |
| Lynn Community Health Center | Not Specified |
| Malden Overcoming Addiction | Not Specified |
| Massachusetts Health Policy Forum at Brandeis University | Not Specified |
| Massachusetts Taxpayers Foundation | Not Specified |
| Mattapan Community Health Center | Not Specified |
| Municipal Naloxone Bulk Purchasing Program (Commonwealth of MA) | Not Specified |
| New Health Charlestown | Not Specified |
| Police Assisted Addiction Recovery Initiative (PAARI) | Not Specified |

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|---|---|
| Recovery Research Institute | Not Specified |
| Rhode Island Hospital | Not Specified |
| Shatterproof | Not Specified |
| The Philanthropic Initiative | Not Specified |
| Tufts University School of Dental Medicine | Not Specified |
| Tufts University School of Medicine | Not Specified |
| University of Massachusetts Medical Schoolâ€™s Center for Health Law and Economics | Not Specified |

## Expenditures

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|---|---|
| **Total CB Program Expenditure** | **$36,811,666.00** |

| CB Expenditures by Program Type | Total Amount | Subtotal Provided to Outside Organizations (Grant/Other Funding) |
|---|---|---|
| Direct Clinical Services | $26,305,621.00 | $5,000.00 |
| Community-Clinical Linkages | $844,893.00 | $72,675.00 |
| Total Population or Community-Wide Interventions | $5,303,071.00 | $3,236,828.00 |
| Access/Coverage Supports | $4,358,081.00 | $702,450.00 |
| Infrastructure to Support CB Collaborations Across Institutions | $0.00 | $0.00 |

| CB Expenditures by Health Need | Total Amount |
|---|---|
| Chronic Disease with a Focus on Cancer, Heart Disease, and Diabetes | $6,307,897.00 |
| Mental Health/Mental Illness | $3,520,165.00 |
| Housing/Homelessness | $414,334.00 |
| Substance Use | $1,198,412.00 |
| Additional Health Needs Identified by the Community | $25,370,858.00 |

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|---|---|
| Other Leveraged Resources | $6,663,256.59 |

| Net Charity Care Expenditures | Total Amount |
|---|---|
| HSN Assessment | $27,465,665.34 |
| HSN Denied Claims | $525,358.27 |
| Free/Discount Care | $2,327,879.39 |
| Total Net Charity Care | $30,318,903.00 |

| | |
|---|---|
| **Total CB Expenditures:** | $73,793,825.59 |

| Additional Information | Total Amount |
|---|---|
| **Net Patient Service Revenue:** | $2,373,723,765.00 |

| | |
|---|---|
| **CB Expenditure as Percentage of Net Patient Services Revenue:** | 3.11% |
| **Approved CB Program Budget for FY2020:** (*Excluding expenditures that cannot be projected at the time of the report.) | $73,793,825.59 |
| **Comments (Optional):** | Not Specified |

## Optional Information

| | |
|---|---|
| **Hospital Publication Describing CB Initiatives:** | Not Specified |
| **Bad Debt:** | Not Specified |
| **Bad Debt Certification:** | Not Certified |
| **Optional Supplement:** | As one of the largest employers in New England, Partners HealthCare, and its founding academic medical centers, BWH and MGH, are committed to leveraging our business practices around inclusive local hiring and workforce development, local and diverse sourcing and place-based investing to tackle underlying causes of poor health outcomes in the communities we serve.<br><br>BWH recognizes the impact of social and economic factors on individual and population health outcomes and provides a number of program and initiatives focused on workforce development as described in other areas of this report.<br>BWH's Indian Health Service (IHS) is one of the reported community benefit activities and inclusion of this activity in the AG Report is based on needs identified through a process outside of the CHNA as well as a longstanding partnership with an external organization. BWH has partnered with IHS since 2008 to support clinical practice and patient care at identified IHS sites. These sites include IHS hospitals in Gallup and Shiprock, New Mexico and an IHS hospital in Chinle, Arizona. These sites serve American Indian communities in rural locations. Data from these sites demonstrate a need for this clinical partnership as IHS reports a shortage of staffing with a nearly 15 percent vacancy rate in essential clinical positions, including access to specialty services and consultations. To address this challenge, BWH physicians volunteer on site and lead educational and remote-teaching sessions, which are broadcast to IHS clinical colleagues. IHS clinicians are also hosted at BWH.<br><br>To fulfill its implementation strategy, BWH will leverage current and future resources to advance its community benefit mission and to address the priority areas identified in the 2019 CHNA/CHIP. BWH will specifically commit staff and other resources through its Center for Community Health and Health Equity (CCHHE), its two licensed community health centers, and other community facing programs. The CCHHE offers 18 distinct community health programs, all of which address the top community health priorities in BWH's priority neighborhoods as identified through the CHNA/CHIP process. In addition, BWH will leverage current and future DoN resources to advance its implementation strategy and will do so in partnership with its many community partners.<br><br>In addition to commitments made by the Brigham and Women's Faulkner Hospital, Partners HealthCare makes system investments aimed at:<br>* Addressing critical public health issues impacting all of our communities. In response to the opioid overdose crisis, RIZE Massachusetts Foundation is dedicated to expanding access to treatment and other services for opioid use disorder (OUD).<br>* Exposing low income youth to health care and science as a career path. In addition to the hospital programs, system support is provided to Camp Harborview, The Scholarship Program, and Partners Summer Jobs for youth.<br>* Building pathways for professional success for incumbent employees and community residents. The Partners in Career and Workforce Development (PCWD) program addresses the Boston health care industry's need for a highly skilled diverse workforce.<br>* Ensuring access to care for our low income community residents by supporting state program enrollment. Partners Community Health staff provide education and support across the system to ensure that patients on MassHealth, Health Safety Net, and the subsidized Connector plans can access care smoothly across the system. |

* Ensuring access to care for our low income community residents by supporting community health centers. There are 5 licensed health centers operating within the Partners system - MGH Charlestown, MGH Chelsea, and MGH Revere operate through the MGH license; and Brookside and Southern Jamaica Plain operate through the BWH license. In addition, Partners is affiliated with 15 community health centers in Boston (Dorchester, East Boston, Jamaica Plain, Mattapan, North End, Roxbury, South Boston, South End), Lynn, Peabody, and Salem.
* Ensuring access to primary care close to home. Partners provides administrative support to the Mass League of Community Health Centers Provider Loan Repayment Program that recruits primary care physicians to work at community health centers.